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LEGISLATIVE PROPOSALS FOR VA MEDICAL CARE

ORIGINAL

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HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

APRIL 22, 1986

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LEGISLATIVE PROPOSALS FOR VA MEDICAL CARE

Tuesday, April 22, 1986

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington D.C.

The subcommittee met, pursuant to notice, at 9:05 a.m., in room 334, Cannon House Office Bulding, Hon. Timothy J. Penny, presiding.

Present: Representatives Penny, Montgomery (ex officio), Staggers, Rowland of Georgia, Daschle, Hammerschmidt, Solomon, and Rowland of Connecticut.

Mr. PENNY. The meeting will come to order.

On behalf of Chairman Edgar, I want to read his opening statement, and then I will ask the ranking minority member, Mr. Hammerschmidt, to make any remarks he may have. Then at that point we will call forward the first panel.

OPENING STATEMENT OF CHAIRMAN EDGAR

The purpose of this subcommittee hearing is to receive testimony about several proposals related to VA medical care. I welcome our distinguished witnesses as well as visitors.

I have introduced two pieces of legislation that were distributed in advance in order for witnesses to prepare testimony. The bill number for the Vietnam veterans bill is H.R. 4623, and the other bill is still in draft form.

Before we get to the first witnesses, I would like to say a few words about the legislation. The two provisions in H.R. 4623 would have the effect of improving the Vietnam Veterans Readjustment Counseling Program. The first provision would delete the requirement that, by October 1, 1988, readjustment counseling services be provided in VA medical facilities.

As most of you know, readjustment counseling services are currently being provided in facilities that are separate from other VA medical facilities.

What does this provision really mean? It does not mean that vet centers at separate locations will be permanent. If that were the intent, I would not have acted at this time. What this provision means is that the VA will not have to devote time and energy to planning and executing the closure of all Vet Centers. It means that the VA can selectively keep open those Vet Centers that are located in areas of need. It means that the VA can manage more flexibly.

I should note here that last year the Congress removed the arbitrary limit on when Vietnam-era veterans could request counseling. It only makes sense that flexibility now should be given the VA to fulfill that mandate.

The recent recommendation by the Chief Medical Director's Vet Center Planning Committee has recommended this provision. In addition, representatives from each of the major veterans organizations who serve on the agency's Advisory Committee on Vietnam Veterans have voted support for this proposal and there is no opposition among them.

Let me stress that this provision is only intended as a management tool for the VA to make need-based, rational decisions about the readjustment counseling pro-

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gram and the location of counseling services delivery. It is intended to avoid arbitrary legislative restrictions.

The second provision related to Vietnam veterans is the establishment of a readjustment counseling professional fellowship program. Eligibility for this program would be for Vietnam-era veterans who are accepted for study in a post-baccalaureate program in an accredited educational institution and in a field related to the provision of readjustment counseling services.

In exchange for payment of fellowship support, the veterans would sign a written agreement to accept a 2-year position as a readjustment counselor with the Veterans' Administration after completion of the course of training.

There are several advantages to this fellowship program. First, it would allow current Vet Center counselors to obtain academic training to augment their practical experience. Second, for veterans who have not been directly involved in readjustment counseling, it would be an opportunity to gain knowledge and training.

Third, the "payback" provision would ensure an adequate number of highly-trained Vietnam veterans to provide readjustment counseling and to reinforce the successes that have been produced by the Vet Center program.

I am pleased to have introduced this legislation and I encourage all of my colleagues in this subcommittee to support it.

The draft bill to improve the delivery of VA health care has eight substantive sections. Section 2 would authorize the VA to provide respite care. This was something we recommended last year and the House passed it. However, due to opposition from the Senate, it was lost in the confrence on H.R. 505.

In this bill, respite care may include hospital or nursing home care furnished in a VA hospital on an intermittent or temporary basis to a veteran who has been diagnosed as suffering from a chronic illness. He or she must be receiving care at home or in a hospice program which has entered into a cooperative agreement with the VA to provide appropriate care for the veteran. The intent is to offer relief to the spouse or relative who often assumes the responsibilities of caring for a dependent elderly or disabled person.

Section 3 would extend for 3 years, until September 30, 1989, the authority of the VA to enter into contracts with the Veterans Memorial Medical Center in the Philippines for care of U.S. veterans.

Section 4 would amend the procedures for disciplinary boards to streamline the process for title 38 employees. It would define the actions which would be covered under title 38 U.S.C. section 4110 and allow some delegation of authority below the Chief Medical Director. A faster process might well help the employee, but we need to be careful to retain all rights of representation and appeal.

Also, section 4118(g) on reporting special pay comparability for VA physicians and dentists would be amended to extend from 2 years to 4 years the interval between reports.

Section 5 would amend the regional medical education centers authority to allow joint sponsorship of training programs, nonresident students, and training of allied health professionals.

Section 6 would change the period of obligated service calculated under the health professional scholarship program.

Section 7 would amend the VA/DOD sharing authority to allow DOD units as well as DOD facilities to enter into sharing agreements with VA medical facilities.

Section 8 would revise the State home construction grant program regarding priorities, would repeal the limit of grants to any one State, and would allow those project requests a transition period before coming under new rules.

The last section would amend the VA and community sharing authority by deleting the word "specialized". This would allow medical resources to be shared in areas where there are shortages or other unique problems without the requirement that the resource be, in a general sense, specialized.

The third piece of legislation in draft form from Chairman Montgomery would establish a test program to enhance VA medical center management flexibility. This program would demonstrate that placing broader authority with local management might result in more effective utilization of VA resources and management skills in terms of timeliness and access to care, the number of patients receiving care, the range of services offered, and the quality of care.

This is certainly a long list of items. We will have to move quickly. I certainly appreciate the work that will be required to adequately address these topics in our allotted time.

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Mr. PENNY. I would now recognize the ranking member of both the subcommittee and the full committee, John Paul Hammerschmidt.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Chairman. Good morning to you and all our witnesses for today's hearing on several legislative proposals for veterans' health care.

We all know only too well how tight VA's budgetary situation is going to be for the immediate future and, consequently, it is imperative that every proposal be administered a litmus test for economy and efficiency.

We have before us H.R. 4623 to repeal the current requirement that veterans readjustment counseling be done at VA medical facilities by October 1, 1988. Unless something is changed, one must wonder why this provision of law should be repealed before the Administrator files his report on readjustment on April 1 of next year. Perhaps this hearing can shed some light on this question.

Also, H.R. 4623 would provide for a new fellowship program for readjustment counseling professionals. It would be nice not to have to keep bringing up the budget. Nevertheless, any proposal for new spending must be subjected to extraordinary close scrutiny when the ability of the VA to provide the most basic and essential health care services is being severely strained. Thus, we will have to determine if a new fellowship program is among the most essential of VA's needs.

We sometimes hear that too many restrictions are placed on medical center directors for them to run their facilities as well as they might. If loosening some restrictions would improve service to veterans, or allow more economical service without cutting quality, a pilot program would appear to be timely in order to test the concept. Such a program is in draft form and we welcome the views of our witnesses on the draft bill.

Finally, there are a number of proposed improvements for VA health care programs embodied in another draft bill. Our committee has proposed some of these before, such as respite care and revision of the grant program for State home construction. Other proposals come from the VA, whose witnesses will speak to them today.

We are working hard to ensure that our veterans continue to receive the benefits they have earned and so richly deserve. Veterans organizations, the VA, and the congressional committees on Veterans' Affairs are all dedicated to the veteran and are all doing everything possible to prevent indiscriminate cuts in funding for the VA. Part of the solution is to look for and find better ways to serve veterans. Today we are going to try to identify some of those better ways.

Thank you, Mr. Chairman.

Mr. PENNY. Thank you, John Paul.

Are there any other members of the subcommittee who want to make opening remarks on the legislation before us? If not, we will call forward Dr. Gronvall, Deputy Chief Medical Director of the Veterans' Administration.

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Dr. Gronvall, as you take your chair, would you please introduce those members of your staff who are in attendance with you.

STATEMENT OF JOHN A. GRONVALL, DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION; ACCOMPANIED BY ROBERT LINDSEY, DIRECTOR FOR OPERATIONS, DEPARTMENT OF MEDICINE AND SURGERY; RALPH IBSON, DEPUTY ASSISTANT GENERAL COUNSEL; JOHN C. MATHER, ASSISTANT CHIEF MEDICAL DIRECTOR FOR GERIATRICS AND EXTENDED CARE; ARTHUR S. BLANK, DIRECTOR, READJUSTMENT COUNSELING SERVICE; THOMAS J. PRICE, DEPUTY DIRECTOR, MANAGEMENT SUPPORT OFFICE; AND JAMES M. HAHN, DIRECTOR, ACADEMIC AFFAIRS OFFICE

Dr. GRONVALL. Thank you very much, Mr. Chairman. It's a pleasure to be here to testify before the subcommittee here.

At the witness table I have, to my right, Mr. Robert Lindsey, who is Director of Operations in the Department of Medicine and Surgery, and to my left is Mr. Ralph Ibson, from our General Counsel's office. A number of other staff from the VA are also in attendance and are available in case specific questions from the subcommittee need a more detailed response.

Mr. Chairman, I would ask that the detailed statement that we have presented be incorporated in the record of the hearing.

Mr. PENNY. Without objection.

Dr. GRONVALL. Thank you very much.

In order to summarize, I think I can give a quite brief opening statement. I will first give a listing of those topics in the several bills that we have reviewed where we support the proposal or the general concept of the proposal. On a number of these items that I will list are our detailed technical comments, urging that we work with the committee staff to perfect the legislation. In summary, then, we are supporting the follow measures in the legislative package:

First, the extension of the authority to pay for care in the Philippines and to make grants to the medical center in the Philippines.

Second, extending the authority to make grants to the States for the State home construction and renovation program, and for removal of the limitation on the amount that can be approved for any one State.

Next we support amending the provision of the law authorizing our regional medical education centers to accomplish the purposes as described. We support the pilot effort to provide respite care to service-connected veterans. We support expanding the scope of community sharing with some additional modifications and some clarifying limitations that are described in our formal testimony.

We support extending to 4 years the interval between the reports that we make on physician and dentist pay, and we support the proposed modification of the method of calculating the obligated service period for recipients of scholarship awards.

We support the revision of the disciplinary board procedures under title 38, again with some clarifications as described in our formal statement. And we also support the pilot program, the management pilot program in which some five medical centers would

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be freed of certain statutory requirements in a way to be determined by the Administrator. We agree that that could produce useful information in regard to having a more efficient and effective operation.

So, having listed those provisions that we support, let me comment on some other parts of the legislation package that we think warrant further development.

First, in regard to the State Home Grant Program, the legislative proposal would revise the basis of making grants to the States for State home construction. The current law provides that once the VA approves a grant proposal by meeting certain specific and qualifying conditions, then the proposal, as approved, is funded in order of priority as the applications were received and as funds became available. The proposed legislation would make a substantial revision in that approach and would establish need as determined by the VA as a basis for funding.

We interpret this proposal to be based on the assumption that the present method of approving and funding State grants fails to address VA's need for State home facilities. I think the fact is that we believe that in an overall way the State Home Grant Program as now constituted, when coupled with our own planning processes and our planning for VA facilities, does address the VA's perspective on the State homes.

We are concerned about the present legislative proposal because, as it stands, we believe its enactment might, in fact, discourage some States from applying. At the present time, when a State undertakes the expense of preparing and submitting a formal application, the State does have the assurance that if the application is approved, it will, in fact, eventually be funded and so the project will go forward.

The proposed legislation would eliminate that fact and would add considerations of need and priority in such a way that, even if approved, the project might not have a sufficient priority so that the project would go forward, and this reassessment of need could change from year to year and would introduce a disincentive perhaps to some States.

On the other hand, we clearly recognize that there are valid criticisms of the existing grant program and that it does not perhaps give sufficient weight to relative need among State home projects. Therefore, we conclude that although it is premature to make the kind of change as proposed in the current legislative proposal, we believe that there well may be options that should be taken into account in developing proposed changes to the present approach. In summary, we believe that more time should be allowed to further study this matter, to study all possible options and ramifications of those options before making a specific change to the existing procedure.

Let me go on to some comments on the readjustment counseling program. In your opening statement, and that of Mr. Hammerschmidt, comment was made on the existing law which establishes October 1, 1988, as a point in time at which a change is to be made in the operation and administrative structure of the Vet Center program.

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The current law also provides that during the period prior to October, 1988 certain reports must be made and plans made for the further operation of the Vet Centers or the services they provide. On April 1, 1987, the Administrator, by current law, is required to report to the Congress in a comprehensive way on the effectiveness of the program, and that report is to include recommendations regarding the possible continuation of the Vet Centers. That has also been amended by Public Law 98-160, the law that mandates a study of post-traumatic stress disorder and other post-war psychological problems, which is now underway, and requires that the considerations deriving from that study be entered into the deliberations leading to the Administrator's report to the Congress.

On the basis of the timetable as established in current law, and the fact that the Administrator does have flexibility to review the matter and then come to the Congress with a report on April 1, 1987, we recommend that the committee defer action on the specific legislative proposal that is before us today.

In regard to the fellowship program for readjustment counseling program staff, it is our judgment that at the present time we, in fact, do not have a problem in either recruiting or retaining qualified professionals to work in our Vet Centers. If problems should arise in regard to recruitment, we do have other means to deal with those. We believe there are preferred options under existing laws and authorities, so we therefore do not support the establishment of the proposed fellowship program in regard to readjustment counseling.

Mr. Chairman, that then summarizes the many provisions in the legislative proposal that we support and makes at least brief comment on those elements in the proposal that we have concern about. With that, I and my colleagues will be pleased to respond to specific questions from the committee.

Thank you.

[The prepared statement of Dr. John Gronvall appears on p. 45.]

Mr. PENNY. Thank you, Dr. Gronvall.

To start out with, I have a few questions that I will be asking on behalf of Chairman Edgar.

In your testimony you take a "wait and see" attitude about the Vet Center program's future. Is it true that the proposal contained in H.R. 4623 is the same as the proposal recommended to the Chief Medical Director by the VA's Vet Center Planning Committee after a 3-year study?

Dr. GRONVALL. Yes, it is.

Mr. PENNY. Was the same recommendation as contained in ths bill also endorsed by the VA's Advisory Committee on Vietnam Veterans?

Dr. GRONVALL. I believe the short answer to that is yes. There is an agency-level Advisory Committee on Vietnam Veterans. That group considered the report that you just referred to on at least two occasions. My understanding is that that Advisory Committee did endorse the recommendation that came from the planning committee.

I believe that that recommendation from the agency advisory committee is still being reviewed and, to my knowledge, has not been presented to the Administrator of Veterans' Affairs. So there

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has not been deliberation on the recommendations of that advisory committee. But again, the specific answer to the question is yes.

Mr. PENNY. You just mentioned it has not been acted on by the Administrator.

Dr. GRONVALL. Correct.

Mr. PENNY. Did the Chief Medical Director sign off on this recommendation?

Dr. GRONVALL. The recommendation that came to the Chief Medical Director from a departmental planning committee, the first committee that you referred to, was endorsed by the Chief Medical Director.

Mr. PENNY. Was it also the recommendation of the Department of Medicine and Surgery to support the legislation, or similar legislation?

Dr. GRONVALL. Yes, in the sense that the action of the Chief Medical Director to endorse the recommendation of the report constituted—

Mr. PENNY. Thereby constituted that kind of departmental support?

Dr. GRONVALL. Correct.

Mr. PENNY. Dr. Gronvall, I understand from the testimony of the Vietnam Veterans of America that that national needs assessment of the Vietnam-era veterans mandated by Congress is 6 to 9 months behind schedule, which means that it would be too late for use by us here in this session of Congress.

Since the two reports mandated in title 38 require the results of this delayed study, how can the VA make a decision about the future of the Vet Center program?

Dr. GRONVALL. You're quite correct, Mr. Chairman, that the study was delayed in its initiation. The reason for that was that there were a number of scientific complexities in defining and developing an approved protocol. We think that those complexities have now been resolved, although the study is on a delayed timetable.

In the context of your question, though, in regard to information from the study or other studies that could assist in the decision about the future of the Vet Center, a good deal of information, of course, is currently being collected on utilization of Vet Centers, the kinds of services needed by Vietnam veterans, and the capability of our medical centers or other parts of the VA to deliver those services. So it would not be correct, I think, to conclude that because the initiation of the post-traumatic stress disorder study was delayed, that no valid information could become available to assist in the decision regarding the future of the Vet Center program.

Mr. PENNY. In your testimony you have also taken a "wait and see" attitude about demonstrating the need for the store front Vet Center program. Would you expect the need for such free-standing centers to increase or decrease beyond 1988?

Dr. GRONVALL. As a general answer, I think we have predicted that need would decline beyond 1988. It is certainly possible that there may be some areas of the country where, for geographic reasons, for example, there is not a medical center where Vet Centers might be needed. But I think those kind of questions need to be addressed in detail, looking at geographic areas of the country and

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other factors. It is our assumption that it would be those kinds of deliberations that would form much of the basis of the April 1, 1987 report to the Congress.

Mr. PENNY. Well, you just ans ered the second half of the question, so I will defer to John Paul Hammerschmidt for any questions he may have.

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Chairman.

Dr. Gronvall, I listened with interest to your response to the Chairman's question about the national needs assessment of Vietnam-era veterans and his observation that it may be 6 to 9 months behind schedule. But I never did hear your response about what the prospect is that the report will be filed on time on April 1, 1987.

Dr. GRONVALL. The post-traumatic stress disorder study is a specific study mandated by public act. It is not the same study or report as described in the existing Vet Center legislation that asks that the Administrator make a report on April 1, 1987. So those are two separate studies.

The suggestion of our testimony is that information being accumulated in the PTSD study would assist in the preparation of the report that the Administrator would be required under present law to submit to the Congress on April 1, 1987.

Mr. HAMMERSCHMIDT. So I take it from that response that you are projecting it will be delayed beyond the required date?

Dr. GRONVALL. Yes, I am aware it is delayed. I have been also informed that the 6- to 9-month estimate is a reasonable estimate of the delay that was encountered at the outset in initiating the study.

Mr. HAMMERSCHMIDT. One study that is required to be filed by April 1 is dependent on the other study, and the other study is delaying the one that is actually required to be reported by that date; is that correct?

Dr. GRONVALL. Yes, on the face of it, I believe that is accurate. I think that what will likely happen is that the timetable and process for the PTSD study needs now to be revisited, to see what, if any, information being collected in the early phases of that study might be made available to assist in the preparation of the April 1, 1987 report. And then, as I also commented, I think there is other information being concurrently collected about the organization of our Vet Centers, the kinds of services that Vietnam veterans need and receive in the Vet Centers, and the capability of medical centers to deliver those services. We would see all of that information coming together on a timetable that we believe would allow the Administrator to make the April 1, 1987, report.

Mr. HAMMERSCHMIDT. I wonder if it would be reasonable if, when you do revisit that subject and reassess it, you could, within 60 days, give our committee a letter on the reassessment of where you stand on that study; would that be a fair request to the VA?

Dr. GRONVALL. Yes, I think that that would be a reasonable request, Mr. Chairman.

Dr. Art Blank, who heads our readjustment counseling program, is here. Dr. Blank may want to clarify or expand the comments I have made about the timetable of the study.

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I agree with you, that we have a timetable problem in terms of the delay of the PTSD study.

Dr. Blank?

Mr. HAMMERSCHMIDT. Yes, his response would be welcome and helpful to our committee.

Dr. BLANK. Thank you.

I would say, first of all, that Dr. Gronvall has covered the matter accurately and I think comprehensively. There were some delays in the set up of the study due simply to scientific complexity. I believe that the contract performance in general was quite good. There is some possibility that some of this time will be made up and we are certainly going to try to move it along as quickly as possible.

Mr. HAMMERSCHMIDT. So you think within 60 days you could have a better reading on it in writing to this committee?

Dr. BLANK. Yes.

Mr. HAMMERSCHMIDT. We would be most appreciative of that information.

Dr. Gronvall, how long would it take to study the ramifications of the options on State home construction funding as suggested on page 8 of your statement?

Dr. GRONVALL. I should say right off, Mr. Chairman, I have not thought through an answer to that, and it's an obvious question when we suggest further time be taken. The number of options are perhaps reasonably limited and the number of factors and considerations that would have to be taken into account may be limited on that basis. We would need to confer with other interested parties, the Association of State Veterans Homes, et cetera.

I think that it would be reasonable—and I'm saying this just as I sit here rather than on the basis of any prior consultation—to say that within a period of 6 months we could have a reasonable definition of other options and their ramifications. We might not have a revised proposal, but I think we could have a good fix on what other alternatives might exist at that time.

Again, Dr. John Mather, who is our Assistant Chief Medical Director for Geriatrics and Extended Care, is here. I would ask if he thinks the 6-month estimate would be a reasonable one. I see he is nodding his support.

Mr. HAMMERSCHMIDT. All right. Thank you, Dr. Gronvall.

What is the VA's position on allowing DOD military units to enter into sharing agreements with VA?

Dr. GRONVALL. We support the proposal in the legislation. I can expand perhaps on the comments in our formal testimony in a way that I believe will be helpful.

In our formal testimony we note that the Department of Defense has expressed concerns about the legislative proposal that would call for sharing agreements directly between military units and the Veterans' Administration. I believe that the basis of the Department of Defense's concern is to ensure that the medical authority structure of the Defense Department is fully involved in the development and operation of such sharing agreements. My understanding, based on conversations just within the past day with officials at the Department of Defense, is that they support the concept of developing such sharing agreements and that they believe it would be an easy matter to work with us and with the committee staff to

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perfect or make technical changes in the legislative proposal to assure that the appropriate medical review within DOD takes place on such sharing agreements.

Mr. HAMMERSCHMIDT. So you don't really see any impediment from DOD's attitude; they're cooperative in wanting to develop the sharing agreements?

Dr. GRONVALL. Correct.

Mr. HAMMERSCHMIDT. Dr. Gronvall, couldn't delegation of the Chief Medical Director's disciplinary board appointing authority carry with it the possibility that boards may be stacked against a physician by Administrators too close to cases to be objective?

Dr. GRONVALL. I think that the Chief Medical Director, in delegating authority, has the responsibility to ensure that the process for carrying out that delegation adequately protects the rights of the individual as well as dealing with the responsibilities of the institutions in which the individuals are working, and that there is an appropriate process at the right level of authority so that an objective judgment and an objective panel can be convened to review the matter.

So while the answer is yes, that's a potential risk that could always occur in any disciplinary matter, I do not believe that the fact that the Chief Medical Director delegates that to someone at a lower level of authority within the Department prevents that matter from being appropriately addressed.

Mr. HAMMERSCHMIDT. If disciplinary boards were to hear cases involving off-duty misconduct, wouldn't the VA have to prove a nexus between the misconduct and job performance?

Dr. GRONVALL. That's a fairly technical question and I should probably ask for help in responding.

Mr. Jack Price from our Management Support Office can comment on that.

Mr. HAMMERSCHMIDT. Mr. Price.

Mr. PRICE. Mr. Hammerschmidt, yes. In any case where an employee has been involved in off-duty activities, there has to be a nexus between those activities and some impact on the employee's job.

Mr. HAMMERSCHMIDT. Fine. I thank you, Mr. Price, for your response. Dr. Gronvall, and the balance of the panel, we appreciate your presence here this morning.

Thank you, Mr. Chairman.

Mr. PENNY. Thank you.

As a follow up to a question asked by Mr. Hammerschmidt, I would like to ask you, Dr. Gronvall, that since the State home proposal which is included in the legislation before us today is identical to a provision contained in H.R. 505, which passed the House last year but was deleted by the Senate in the conference committee, why is it that you still need time to study the proposal when you effectively had an entire year to look this idea over?

Dr. GRONVALL. I think that's a valid question. I would say there have been some important new dimensions that need to be considered. I think perhaps the most important one is that the President's budget for 1987, which was devloped and submitted just fairly recently, does present a different or a new or a revised strat-

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egy for the VA in regard to meeting the nursing home care needs of veterans.

You may recall that the 1987 budget describes a strategy of increased reliance on both State homes and on community nursing homes, with a relatively lesser proportion of the need being met by VA-owned and operated nursing homes. Those deliberations went on late last year and are embodied in the budget that has just recently been presented to the Congreess. So there are some important new dimensions I think that cause us now to believe we ought to relook at the matter in all aspects of VA programs that relate to community nursing homes, State nursing homes, as well as the VA nursing home program.

You are quite correct, that the specific legislative proposal before us has been previously before us, and the VA in the past has taken a position in opposition to the change and has said that the existing method of allocating State grant funds should continue unaltered. With the new strategy as now proposed in the President's budget, we now think that should be revisited, but we think there are options other than those embodied in this legislation that ought to also be reviewed. That is the basis for asking that the whole matter be readdressed.

Mr. PENNY. Is your time frame of making a recommendation in this regard within about 6 months something that could be speeded along? You know, we're probably not going to be in session 6 months from now, and if we want to get something done before the start of the next fiscal year, it would be helpful to know earlier than that just what it is the Department feels it should recommend within the strategy that is a part of the current administration's budget policy.

Dr. GRONVALL. When I suggested the 6-month timetable, that was based on about 15 seconds of deliberation while I was sitting here, so there is not very much substance to that 6 month's estimate.

I think, Mr. Chairman, what would probably be a better approach would be that we provide to the committee by letter, within a reasonable time, a suggestion of a timetable and a mechanism for deliberating on the matter and the expected date that we could come back to the committee with a proposal.

Mr. PENNY. We would ask that you do that.

Mr. Rowland.

Dr. ROWLAND of Georgia. Thank you, Mr. Chairman.

The VA now uses extended care facilities in the private sector for patients, particularly when they can't get into a VA facility. Do you know if the is an extended care facility in the private sector strictly for veterans anywhere in the country?

Dr. GRONVALL. I don't know the answer to that. Dr. Mather, do you know the answer to the question?

Dr. MATHER. Mr. Rowland, in referring to the extended care facility, I assume that would be a nursing home. There is no nursing home in the private sector that we know of that is totally devoted to serving veterans.

Dr. ROWLAND of Georgia. Do you have any thoughts about that type of concept, a nursing home just for veterans in the private sector?

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Dr. GRONVALL. Perhaps you could expand a little bit on what's behind the question, if you would.

Dr. ROWLAND of Georgia. All right.

There is an individual in my district, a veteran, who is trying to do just that. He wants to build an extended care facility and he wants to do it just for veterans. I was curious as to whether or not there was any precedent on how the VA might react to that sort of proposal.

Dr. MATHER. Mr. Rowland, we get several inquiries in my office about our position concerning supporting community nursing homes. The position we have taken is that it is our experience in the contract program that there is no problem in placing veterans, and if a private contractor wants to build a nursing home and approaches the closest VA medical centers or others about establishing a standard per diem rate, there are usually no problems with that.

Our experience in the contract nursing home program is very favorable. We do not, though, expect a community nursing home itself usually to be able to just support itself on the basis of only serving veterans. We find a mix of male and female, a mix of other sources of funds, to be more useful for them than just relying on Veterans' Administration funds.

Dr. ROWLAND of Georgia. So you don't look very favorably on that concept then?

Dr. GRONVALL. I think what Dr. Mather has given is our general response, he has made a general description of the way community nursing homes operate. I think it would not be accurate to say that anything that we have said would actually constitute a negative assessment of the merit of such a proposal. We haven't, so far as I know, had such a proposal made to us. I think if it were and we knew the situation, the geographic location, what the need was and what the other elements in the proposal were, then we would review it on its merits. There is no predetermination or predisposition that we would oppose something because it's a new idea that we just haven't heard or responded to before.

Dr. ROWLAND of Georgia. I would like to investigate that a little bit further and see if there would be any advantages to doing something like that. We have State veterans homes where we have just veterans, so I was just curious to know whether or not there would be any advantage to doing that in the private sector.

Dr. GRONVALL. I would say, at a more general level, we have continually testified and taken the position publicly that the nursing home needs of veterans, as we face an aging population of veterans, are large and growing, and that it's going to require combined efforts on the part of the Federal Government, the States and the private sector. The best and most creative and energetic efforts of all of us are going to be needed to meet that need. So our predisposition is that any time we hear a suggested new approach, we would be anxious to explore it in the hopes that that will provide an added dimension to our own planning or other people's planning. So our going-in approach to looking to any new idea I think is very positive because of the projected increase of the need.

Dr. ROWLAND of Georgia. I would appreciate your thoughts on that, if you will do that.

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Dr. GRONVALL. We would be pleased to respond when a proposal is received.

Dr. ROWLAND of Georgia. Let me change direction here just a minute.

Could you tell me what is presently in place insofar as disciplinary action is concerned with an employee at a VA facility, a physician or some other professional person, and what do you propose here? I read what you said, but would you expand on that just a little?

Dr. GRONVALL. Mr. Rowland, I would be pleased to ask Jack Price again to come back to the table, because the matter of discipline is technical, highly structured, complex, and in his position he spends much of his time dealing with the details of it. So in the interest of getting a more accurate answer, I would be glad to have him comment.

Mr. PRICE. Thank you, Dr. Gronvall.

Mr. Rowland, we are dealing with two processes at the local level. One is the title 5 disciplinary process, which impacts the majority of employees at our health care facilities, all those who are not specifically appointed under title 38. That process is set up both in statute and regulations under title 5.

We also have a title 38 process which we at the VA have control over, which is set up under section 4110 of title 38. That currently provides that any employee who faces a proposed disciplinary action more severe than a reprimand is entitled to a hearing before a board of peers—physicians if it's a physician, nurses if it's a nurse—

Dr. ROWLAND of Georgia. May I interrupt you at that point?

Mr. PRICE. Certainly.

Dr. ROWLAND of Georgia. I would ask you about the reprimand. Would you explain to me the reprimand? Does that come from the administrator of the hospital or——

Mr. PRICE. Admonishments and reprimands are lower level disciplinary actions. They are censures, in a sense. Admonishment would remain in an employee's personnel folder for 6 months, a reprimand for a minimum of 2 years. These would normally be issued by the local director, unless the employee were in a position that was centralized to the Chief Medical Director; then they would have to be issued at a higher level.

The actions right now that we're talking about, going to a disciplinary board, are actions where an employee faces a loss of property rights, either salary or position, along those lines.

The hearing process, an adversary-type hearing, is not quite as strict in a legal sense as a court hearing, but the employee is entitled to representation by counsel, and witnesses are called by both management and the employee when we get into the disciplinary board process. It is at this point in time a very cumbersome process because we do cover all actions, from one-day suspensions right on up through removals or reassignments or demotions.

What we are trying to do in our proposal is to streamline the process more along the lines of title 5, which has evolved over the years to be a more efficient process. We certainly are interested in protecting the uniqueness of title 38, but the process as contained in section 4110 has not been modified in a number of years.

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Dr. ROWLAND of Georgia. How is the final decision made?

Mr. PRICE. The disciplinary board makes a recommendation under section 4110 of title 38, to the Chief Medical Director, who may accept, reject, or modify that recommendation based on his review and staff review of the transcript that is kept of the hearing and of the evidence file. The employee is then notified of that decision and may then exercise a right to appeal that decision to the Administrator. If there is no appeal filed, the decision of the Chief Medical Director stands as final.

Dr. ROWLAND of Georgia. Thank you.

Mr. Chairman, if I may make one other comment about your community sharing, which I have found to be extremely good, particularly in my home town. I am just very pleased with that. I am pleased to see that you want to expand that, Dr. Gronvall.

Dr. GRONVALL. Thank you very much.

Dr. ROWLAND of Georgia. Thank you, Mr. Chairman.

Mr. PENNY. I want to follow up for my own purposes on the issue raised by Congressman Rowland a few minutes ago, and that is the contracting with the private health care facility exclusively for VA use.

We have a similar interest in the State of Minnesota. My understanding is that current policy is to certify a home for use by veterans, and then to negotiate on a case-by-case basis the admission of a veteran and the per diem.

How do you envision the process differing if a home simply wants to admit veterans? It seems to me it would be difficult for the home to make that its policy if it isn't guaranteed in a more carte blanche way authority by the VA to make those admissions. If they've got to come case-by-case-by case with each of the 40 or 50 people they want to admit to the home, that doesn't give them the kind of green light they need to go ahead and construct a home for that purpose.

Dr. GRONVALL. Dr. Mather, can you respond to that?

Dr. MATHER. Mr. Penny, I think you raise some serious operational concerns. It implies that we're moving towards the idea of a sole source contract with a given nursing home in the community, I think we've had previous hearings on this subject in which considerable concerns were expressed.

I believe another factor that ought to be mentioned is that in current authority, a veteran that is service-connected has the opportunity to stay in such a home. For the nonservice-connected, there is a statutory limitation on VA support. Thus, that veteran is eligible for up to 6 months of VA supported care. After that they would have to transfer to other funds, such as private pay, or, if they're indigent enough, to medicaid sources of funds.

The way we have viewed this program in the past, is that it is very effective and allows us to negotiate per diem rates that are reasonable, given the geographic area where a given nursing home is located.

Mr. PENNY. So the design of the program currently would make it virtually impossible for the VA to authorize a home to provide care exclusively to veterans, unless somehow they were able to document that they could have a steady flow of disabled veterans ready to utilize their facility?

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Dr. MATHER. I think that's one aspect. The other aspect is that we have felt, with the freedom to negotiate the per diem rates with each nursing home, that it allows us to get the most favorable rate. Also, in negotiating with a variety of nursing homes in the community—10, 12, 15—ranging from distances close by to a VA medical center to great distances, it really serves the veterans' needs in a more precise way.

I think you would have to discuss with the nursing home industry itself a little bit more how they would feel about such a proposal. I think there would be concerns there about the flow of considerable numbers of patients.

Mr. IBSON. Mr. Penny, just by way of clarification, when Dr. Mather speaks of the present design of the program being an obstacle, I think he's describing the way the program has worked and apparently worked very effectively. But the statute would probably permit us to enter into some kind of preferred provider contractual relationship to accomplish this kind of a goal. I would think the Department could explore the feasibility of that approach.

Mr. PENNY. It does seem a preferred provider relationship is not a whole lot different than the Department documenting a need for a VA facility or approving a State VA home, a State veterans home. In both of those instances you're committing yourself to keeping those homes full. And whether they are constructed with Federal or a combination of State and Federal funds or constructed privately, it is a home that is going to be exclusively used by veterans. It seems to me the same consideratons would apply.

It is just that we have never done it with a private facility before. We have always done it in-house.

Mr. IBSON. The relationship with the States, of course—

Mr. PENNY. It seems to me that the decision-making process before you set up a VA nursing home, and the process by which you participate in a State-owned nursing home, would not be any different than the process you would need to go through to certify a private home exclusively for VA use, because in all three cases your prime consideration has to be that the demographics demonstrate a need that would keep that home full.

Is that a fair assessment?

Dr. MATHER. Mr. Penny, in the planning process we do carefully look at the demographics of a given area. It is this overall mix we're striving for, as Dr. Gronvall referred to earlier.

To make another point, State veterans homes are not obligated to have all veterans in those homes. Only when they receive construction money do they then have an obligation to have 75 percent veterans in those homes. In fact, many homes have the spouses of veterans and other non-veterans. It's purely a State home decision.

In the community nursing home program, usually you would expect veterans in those community nursing homes to be no more than 10 to 15 percent of the population in those homes. I think many of those homes in the community are concerned that there be a mix of funding sources and not become dependent on one financial source for maintaining their occupancy.

Mr. PENNY. I know you have indicated in your testimony that you're going to give this option some consideration. The reason we

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think there may be some value in giving it more attention than perhaps you have in the past is that in at least certain regions of the country we may not be in a position where the budget allows a VA nursing home, and we may not be in a position where that State's nursing home is high enough on our priority list, and yet there is a demonstrated need. This is one way, simply offering per diem for care, that we can get those homes built more rapidly than perhaps we can under our existing programs.

Again, we have a specific case in Minnesota—apparently there's one in Georgia as well. They may or may not meet all the proper criteria, but it does seem to me there may be areas in the nation where this is an option that we ought to pursue.

Dr. GRONVALL. Mr. Penny, we will certainly be pleased to follow up, both in a general way on the questions that have been raised here, and specifically with you and Mr. Rowland, to be sure that we know the thinking that's going on in your particular areas. We will be pleased to explore this again in a very positive way.

Mr. PENNY. Thank you.

I have some additional questions, but I want to——

Dr. ROWLAND of Georgia. Mr. Chairman, could I pursue this just a little bit further?

Mr. PENNY. Yes, we might as well take care of it before we move on to something else.

Dr. ROWLAND of Georgia. I just wanted to say Dr. Mather certainly raises a valid point and that we might encounter objections from the private sector nursing homes, feeling they might be in competition with the VA homes.

While we don't want to be in an adversarial position with the private sector, we all know that Public Law 93-641, the National Health Planning Resources Development Act, wanted to dismantle the VA system that we have in place now and push more of it into the private sector. So I'm not really concerned about the kind of response that we might get from the private sector. In fact, we might be able to work with the private sector, just as we do in community sharing now, if we approach it in the right manner.

The fact is that if we could develop some sort of system that would be more cost effective, that would reduce the cost to the VA, I certainly think we ought to look into that.

Dr. GRONVALL. Absolutely.

Dr. ROWLAND of Georgia. Thank you.

Thank you, Mr. Chairman.

Mr. PENNY. The chairman of the full committee, Mr. Montgomery, has arrived. In deference to his busy schedule, I want to allow him an opportunity to make whatever statement he may want to make and pursue questions of this panel.

Mr. MONTGOMERY. Thank you, Chairman Penny, and thank you for chairing this subcommittee today. I want to thank both the Rowlands also for being here.

Mr. Chairman, one reason I was late this morning is that many of us have Close Up students here from our home districts and communities. Mine are from Starkville, MS. That's where the great Mississippi State University is located. They're not bashful. They jump right up there. I would like to have them stand up.

(Applause.)

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We're very glad to have them.

Dr. ROWLAND of Georgia. Are they "Bulldogs", Mr. Chairman?

Mr. MONTGOMERY. They're "Bulldogs". We're trying to get as good as the Georgia Bulldogs some day.

Also, Mr. Chairman, I appreciate our witnesses here from the VA being here. I would like to say to my colleagues that I have been working on a State veterans nursing home for Mississippi, and Dr. Mather is key to this. We hope that it will stay on track.

I think the discussion is good here, in the short time I have seen. We're going to have to work any way we can, Tim, and maybe we might have to change some things to get more State veterans nursing home and any other type of nursing home to be able to take care of these veterans down the line. We know what's going to happen. We're really going to have a lot of these older veterans in the next 4 or 5 years that will be living in the different States and are really going to need some help. I would like to see them live in dignity and have an opportunity to be taken care of in cleanliness and with their comrades in the latter part of their lives.

Let me read this statement, too, Tim. I feel strongly about this statement. Some in the room today will disagree with what I'm going to say, but I think we have to point out that one of the bills—I'm not opposed to it at the proper time. I just don't think we should have any action now by this subcommittee, and that's H.R. 4623. I want to make my observations pertaining to this legislation.

Because of the timing, because of Gramm-Rudman, I'm not too sure we're ready to make some firm lock-in actions, in that we might have to come back and make further cuts. So I would like my full statement to be put in the record.

Mr. PENNY. Without objection.

[The prepared statement of Chairman Montgomery appears on p. 75.]

STATEMENT OF HON. G.V. "SONNY" MONTGOMERY, CHAIRMAN, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. MONTGOMERY. We have been successful in the past in protecting veterans benefits from significant budget reductions. However, our ability to continue these successes certainly is becoming harder each year. You will recall we had difficulty in the committee last session in meeting cuts contained in the budget resolution, and what will be required in the future, I believe, are explicit actions to show our colleagues that we conserve VA's resources.

Such actions must include thorough reviews of the programs and the cost-effective use of funds and personnel. These acts alone will convince our colleagues that authorizing and appropriating funds for the VA is a sound public policy decision. One example is our recent improvement in eligibility for VA health care benefits. We took a minus and, in effect, turned it into a plus, Mr. Chairman, on health care benefits.

I am here to present to the subcommittee my personal views on H.R. 4623, regarding readjustment counseling. One provision in the bill would eliminate the requirement that Vet Centers begin delivering services primarily through VA medical centers by October 1, 1988. My approach might not be exactly correct.

As you know, Vet Centers now provide services primarily in facilities situated apart from VA medical centers. The other provision would establish an academic fellowship program for Vietnam era veterans to learn readjustment counseling skills. In exchange

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for fellowship support, service as a readjustment counselor in the VA would be required.

Now, I want you to know that I cannot support either of these two provisions at this time. I want to stress that. As I read the bill, this provision would make permanent the Vet Center program in its current configuration. I can't say that the bill is intended to do that. However, that is how this legislation will be perceived should it be adopted.

Now, if I am wrong in my reading of the bill, then there is no reason to act on this provision now. Eighteen months remain before any action on the program is required by law. Indeed, we should exercise responsibility and wait until we have received the VA's reports on their recommendations concerning the Vet Center program and its future, which we required the agency to do.

This is important. We passed legislation that mandated two reports in Public Law 98-160, due in April and July of 1987. These reports concern the effectiveness of the Vet Center program and plans for the future of the program. They might come back in and say we need the Vet Centers and we'll consider them. But what I'm saying is, let's get the reports in before we permanently lock in these Vet Centers.

In addition, the Congress has also mandated a study of post-war psychological problems which is due on October 1 of this year.

It is not wise, as a matter of policy, to anticipate the results of these reports. I further think it is not wise as a matter of conserving the VA's medical care budget to act without benefit of sound information. In other words, it is premature, in my opinion, to act on this bill.

With regard to the proposal to establish a fellowship program for counselors, it is unwise to divert scarce medical care funds to a new program, particularly when there has been no evidence presented to the committee that the VA is having difficulty recruiting qualified Vet Center staff. Remember, the VA has reported turning away over 35,000 non-service connected veterans who apply for outpatient and long-term health care each month. Where is the money for another new program? That's really what I'm coming down on. I'm worried about Gramm-Rudman and I'm worried about locking in programs and starting new programs.

As you may also recall, the administration did not request any funds for the nurse scholarship program for fiscal year 1987, notwithstanding the nurse recruiting problems that exist in some facilities. I cannot endorse authorizing this new fellowship program when we cannot fund adequately the existing nurses program, which is the most important?

Certainly I understand the political appeal of this bill. As chairman of the committee, I also understand how difficult it is for us to make cuts in existing programs when we were required to do so in reconciliation bills in years past. Remember the split in the committee, Mr. Chairman, last session when we were mandated to save about $1 billion over 3 years. It was a tough vote for a number of us. Twelve members voted no on the measure to make any savings that Mr. Hammerschmidt and I proposed.

Let us not make our work tougher by acting to fix a recruiting problem which has not been shown to exist or by prejudging the

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contents of reports we have asked for concerning the outreach program. If we see that something needs to be done, we can do it next year. There is no reason to move this bill now. Let's remember we have not passed a budget resolution for fiscal year 1987, and we may be mandated to cut back on existing programs again for the 1987 reconciliation process.

Mr. Chairman, in walking over here I ran across Chairman Bill Gray on the Budget Committee. I was supposed to meet with him last week and he canceled it out. But he told me, he said "We're going to take care of you." I don't know what type of "taking care of" it is. I would like to take another look at it.

(Laughter.)

So we're going to have some problems here in moving ahead too quickly on H.R. 4623. I plan to oppose it and I just wanted to put this in the record. Thank you for giving me this opportunity.

Mr. PENNY. Thank you, Mr. Chairman.

I have several questions that I want to pursue on behalf of Mr. Edgar. I will hold those for a little while because there are questions on several items in the legislation before us that I want Dr. Gronvall to address.

Dr. Gronvall, in the statement of the National Association of State Veterans Homes, mention has been made of a proposal by the VA to discontinue the Office for Geriatrics and Extended Care as presently established. Do you have any information on this legislative proposal?

Dr. GRONVALL. I'm aware of the administrative reorganization proposal that we made. It would alter the structure of our Central Office administration. There has been concern expressed, as you are quoting, that this might represent a downgrading or lessening of the interest of the VA in matters of long-term care in geriatrics. I would assure you that that is not the case. The intent, in fact, was quite the opposite.

By restructuring our administrative organization, it was an intent to ensure that all of the deliberations in the Department of Medicine and Surgery having to do with our medical program, surgical programs, all of our hospital care programs, as well as nursing home programs, could be better focused on the needs of an aging veteran population. So the intent was really to strengthen and broaden the focus on medical and other needs of aging veterans.

Mr. PENNY. Would there still be an Office for Geriatrics and Extended Care?

Dr. GRONVALL. It has been some time since I looked at the specific proposal, so I'm having to rely on my memory. I believe the proposal that we have developed would not have an Assistant Chief Medical Director or an office specifically labeled "Geriatrics and Extended Care".

Mr. PENNY. So how would it be configured? What assurance do we have this area is going to receive the attention it deserves if there isn't a director specifically assigned the responsibility in this area?

Dr. GRONVALL. Again, it's been some time since that proposal was being discussed, but my recollection of it is that the responsibilities for program review and programmatic initiatives having to

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do with all of the needs of an older veteran population would be combined into our Clinical Affairs Office, where a broader focus of all program planning for hospital and other programs in the Department would be brought to bear on the needs of older veterans.

Mr. PENNY. Dr. Gronvall, what activities has the VA been involved in regarding respite care?

Dr. GRONVALL. Excuse me. Could you repeat the question?

Mr. PENNY. Referring to respite care, what have we been involved in so far?

Dr. GRONVALL. Dr. Mather, can you comment, please?

Dr. MATHER. Mr. Chairman, there have been some informal experiments on a pilot basis established within our existing authority. One of particular note is the program going on at Palo Alto at the VA medical center there in conjunction with the GRECC program. That is the only one we have been monitoring.

Other facilities have been looking at the issue of respite care and what might be done, particularly at the St. Louis VA medical center, which also has a GRECC. There is no specific respite care program that is formally established. There has just been some attempts to look at the issue in conjunction with a couple of the GRECCs.

Mr. PENNY. If the proposed legislation passes, what will your plans be for respite care?

Dr. MATHER. We would provide what we believe would be excellent respite care, in the sense that there would be a planned admission for a veteran to a nursing home or a hospital bed. We would do it, as we have proposed, on a pilot basis, to get some experience with it and limit it to service-connected veterans. That would be our proposal.

Mr. PENNY. Thank you, Dr. Mather.

I want to back up before I move on to respite care because there was a follow up that I wanted to ask on the geriatrics and extended care issue.

Does that recommendation to collocate all of these programs for the elderly veterans population need legislative action, or can you do that administratively?

Dr. GRONVALL. Let me make a comment and then I'll ask Mr. Price to expand on it.

I believe that the principal basis on which our legislative proposal was developed was to reduce statutory mandates for the exact structure of the Chief Medical Director's office and the names, titles and numbers of Assistant Chief Medical Directors. It was an intent, really, to create more flexibility for the Chief Medical Director to review all of the needs of the Department of Medicine and Surgery and then structure the Central Office in a way that best responded to those needs and gained initiative in planning for the future. So that was the most important principle that we were trying to address.

Now, Mr. Price can comment more specifically on the way the proposal handled the ACMD position for geriatrics and extended care.

Mr. PRICE. Thank you, Dr. Gronvall.

Mr. Penny, right now section 4103 of title 38 mandates that the office of the Chief Medical Director have a certain structure. It

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does mandate that we have an ACMD for Geriatrics and Extended Care.

The proposal we made is one to allow the CMD to streamline his office, and it would still provide for the creation of seven ACMD slots and would allow the Chief Medical Director to designate, if he so chose, one of those to be an ACMD for Geriatrics and Extended Care, or give it some other title, some other emphasis. So the opportunity to do that is still there. What it does is, among a number of things, eliminate the mandated office. But the proposal did not single out geriatrics and extended care. It was saying that all of the requirements in section 4103 that demanded the CMD have specific positions within his office be eliminated .

Mr. PENNY. It does require legislation to approve that kind of administrative realignment?

Mr. PRICE. Yes, it would. It would require as change to section 4103.

Mr. PENNY. Okay, thank you.

Dr. Gronvall, I have a whopper for you here.

Dr. GRONVALL. I'm ready.

Mr. PENNY. The amendment to section 4110 would limit the appointment of disciplinary boards to suspension exceeding 14 calendar days the motions involving loss of grade or pay and discharges of employees appointed under section 4104(1).

How would you address the appeal or grievance process for suspensions of less than 14 calendar days, directed transfers between VA facilities, directed reassignments within VA facilities, reductions in rank without a corresponding reduction in grade or pay, and changes in duty assignments?

Dr. GRONVALL. I am once again very pleased that Mr. Price is here, and I think he can specifically answer that, because the answer is available.

Mr. PENNY. Mr. Price.

Mr. PRICE. Mr. Penny, we would address those changes under regulation and provide coverage for suspensions of 14 days or less and the other actions you named under the title 38 grievance procedure, which would allow the Chief Medical Director or designee to appoint a hearing officer, a single individual, as opposed to a board of peers, who would go to the facility and conduct an informal hearing, obtain all the facts, develop a record, and then make a recommendation to the Chief Medical Director or the appropriate designee on the appropriateness of that action. There would then be an appeal to a higher level authority of that decision.

It brings those actions into conformance with the current structure for title 5 and would reduce the number of 4110 disciplinary board hearings the VA would have to have, saving time and money while affording employees appropriate due process.

Mr. PENNY. In that regard, would you object to specifically providing for representation for the employee in those circumstances?

Mr. PRICE. No, not at all. In fact, our regulations would provide for the employee to have representation.

Mr. PENNY. Thank you, Mr. Price.

Dr. Gronvall, what facilities and what services have been denied approval under the VA community sharing authority as it is now

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written? How would the deletion of the word "specialized" affect the scope of the program?

Dr. GRONVALL. Let me ask Mr. Lindsey, who is our Director of Operations, to comment on that, because he handles the details of those proposals.

Mr. PENNY. Mr. Lindsey.

Mr. LINDSEY. Thank you.

Just to give you some examples of some areas where this new authority will allow us to share and where we have been prohibited from sharing in the past—for example, a driver training program for the handicapped, wider sharing for routine lab tests, sharing of our library services or even our dietetic services, getting into those areas of less than specialized health care delivery services.

Mr. PENNY. Thank you. I appreciate the answer.

Dr. Gronvall, are you contemplating any changes in the special pay for VA physicians program?

Dr. GRONVALL. Consideration is always being given to our special pay provisions. We make the specific report which contains provisions on a periodic basis, so that becomes the focal point then for bringing all of that together. At the present time we do not have proposals that are actively being presented for action.

Mr. PENNY. But has the nature of the recruiting and retention problem changed since 1980?

Dr. GRONVALL. Yes. I think there are some quite important changes going on in the country in regard to the market, if you can use that term, for recruiting and retaining physicians and dentists. So it is important to periodically in a formal way address that matter through the report that we submit.

Mr. PENNY. Why does it take 18 months to develop the report when the Office of Data Management and Telecommunications has a computer program that provides the data?

Dr. GRONVALL. Well, we have data within the VA regarding the amounts that are paid and the number of people in our physician and dentist staff, et cetera. But the intent of the report, the reason for the report, is to collect data about the salary and pay status of physicians and dentists outside the VA so that the VA will have the information about what the total professional marketplace is in the country to ensure that the pay system within the VA keeps us in the position where we can be competitive and retain the best physicians for care of veterans in the system. So, in short, the data do not exist within the VA anywhere to respond to those questions.

Mr. PENNY. With regard to the Regional Medical Education Center program, what has been the history of training other than VA employees in the RMEC?

Dr. GRONVALL. Let me call on Mr. Jim Hahn, who is in our Academic Affairs Office and who handles the details of the Regional Medical Education Centers program, to respond to that.

Mr. HAHN. Virtually none. We from time to time will get people from DOD and that's just about it.

You're talking about outside the Veterans' Administration?

Mr. PENNY. Yes. But you haven't had any involvement other than DOD?

Mr. HAHN. DOD and a few others.

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Mr. PENNY. With the proposed change to the sharing provision in section 5053 of title 38, will the authority be adequate to permit cosponsorship of RMEC programs with other than VA entities?

Mr. HAHN. Yes. As we indicated in our formal testimony, additional statutory changes beyond those proposed would be necessary to provide authority under which cosponsorship of REMC programs could generally be undertaken with non-VA entities. Simply eliminating the term "specialized" from sections 5052 and 5053 will not necessarily permit such cosponsorship to occur.

Mr. PENNY. Do you have any plans to change the organizational structure or administrative procedures of the RMEC program?

Mr. HAHN. No.

Mr. PENNY. You do not.

Mr. HAHN. No.

Mr. PENNY. Thank you. I appreciate your answer.

Dr. Gronvall, if joint sponsorship of Regional Medical Education Centers were allowed between VA and non-VA entities, what actions would have to be taken by RMECs to address conflict-of-interest considerations?

Dr. GRONVALL. Jim?

Mr. HAHN. I don't know that specific actions would be called for. We are very sensitive to the conflict-of-interest question. There is always a possibility that there is, for example, pharmaceutical company money behind the university program, and because we are sensitive to that, we just wouldn't get involved with it. That's sort of part one.

Part two is that we really wouldn't be seeking out partnerships in training unless the training were something we had already identified as being needed by us.

Dr. GRONVALL. I might just add to that comment that whenever we enter into sharing agreements, contractual relationships, formalized agreements, with any agency or institution outside the VA, those agreements get wide scrutiny within the VA. In fact, if we have a problem, it is that the amount of scrutiny we bring to bear on those questions causes a long timetable to be imposed on the development of such agreements. So in the process of reviewing such proposed sharing agreements with the RMEC, those questions would be formally addressed by legal counsel specifically.

Mr. PENNY. Thank you.

Dr. Gronvall, in your testimony you support the proposed change to the calculation of employment time owed the VA for part-time students under the Health Professionals Scholarship Program. If it were passed, what would be the impact on the students themselves?

Dr. GRONVALL. Mr. Hahn again.

Mr. HAHN. Virtually none. What it will do for the student is—and you have to bear in mind there are only 22 of them left—is assist them for the first time to calculate with reasonable accuracy how much they're going to owe us.

In the past, with the calculation mechanism we use now, which I think is a four-step process, there is really no way for that student to know from year to year, what they owe. So it's just going to simplify it. It's really a method that looks forward to the future. If we

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activate similar kinds of programs then we'll have an easier method to do that for part-time students.

Mr. PENNY. Would the total period of obligation for the student be longer than the current system?

Mr. HAHN. Probably not.

Mr. PENNY. Thank you.

Finally on my list of questions, Dr. Gronvall, you support in your testimony the 3-year extension of the authority of the VA to enter into contracts with the Veterans Memorial Medical Center in the Philippines for care of U.S. veterans.

Has the VA had any communications with the Philippine government regarding this authority?

Dr. GRONVALL. I have raised that question myself, and we had inquired in regard to the change of government. Mr. Ibson may want to comment on that.

Mr. IBSON. Mr. Penny, we were advised essentially that the executive branch expresses confidence that nothing has changed with respect to the Philippine government's relationship to these ongoing programs. We have approached the measure from that perspective.

Mr. PENNY. You haven't had any direct contact between the VA and the government there, but you're operating on the assumption that there is no change in policy?

Mr. IBSON. I can't respond to that specifically, sir. The information we got was from officials who had dealt with the State Department.

Dr. GRONVALL. But the answer to your question specifically is no, the VA itself has not specifically raised that question with the new government of the Philippines. This is a matter that's been handled through the executive branch, the White House, and that's where our information comes from.

Mr. PENNY. I have a few questions that I want to pursue on behalf of Chairman Edgar. I would like to call Dr. Blank forward to answer these, since it is his program.

Dr. Blank, I would not ask you for formal positions on the bill. However, I think these questions need an answer from someone of your personal and professional judgment.

First of all, the present law on the readjustment counseling program contains a provision that Vet Centers close by October 1, 1988. What is your assessment of the effect of that provision on the Vietnam veterans counseling program?

Dr. BLANK. Well, first of all, I think I would have to say that apparently the program is doing rather well, judging from the continuing high numbers of veterans and family members who are using Vet Centers and the generally high regard which most Vet Centers have in their community.

I would say that the termination date provision does present an obstacle that we have to work against and overcome in terms of recruitment and retention.

Mr. PENNY. What is your opinion about the effect on the Vet Centers as they are now operating if that provision would be removed?

Dr. BLANK. Well, I think I would have to look at that from a relatively narrow perspective. I'm certainly not aware of many issues

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affecting resources and competing needs. My position is that of being a representative of this particular program.

With that caveat, I would say, in general, it probably would have felicitous effect.

Mr. PENNY. In your judgment, would removing the termination date cause parts of the program to remain in place past the time when they are needed?

Dr. BLANK. Well, I think most of the staff of this program are Vietnam veterans and the program has been developed thereby with integrity and is being operated with integrity. I think under any possible circumstance in the future it will be operated in the same way.

If I may say, I think most of the staff of this program are committed to accomplishing the mission rather than establishing structure and would agree that the program should evolve in such a way that reflects completion of the mission.

Mr. PENNY. As Director of the Vet Center program for the past 4 years, what is your opinion on the direction this program should take in the future?

Dr. BLANK. Again, I would emphasize that I'm not in a position to take into account various other conflicting priorities which are quite significant at this point in time with respect to resources. But, in general, I would favor a gradual downsizing model for the future of the program.

Mr. PENNY. I thank you, Dr. Blank, for your answers to those questions.

At this time I have a document signed by Dr. Ditzler, Chief Medical Director, speaking to the Readjustment Counseling Program that Chairman Edgar would like to have included in the record. Without objection, that memorandum will be added to the committee record on this issue at this point in the record.

[The requested document appears on p. 83.]

Mr. PENNY. I have no further questions of you, Dr. Gronvall, or your panelists, but I would defer to any members of the subcommittee who may want to pursue additional questions before we call the next panel.

Dr. Rowland?

Dr. ROWLAND of Georgia. Thank you, Mr. Chairman.

I want to raise a point that I raised once before, and that is hospice care for veterans. Are you doing anything in this area specifically for that?

Dr. GRONVALL. I would ask Dr. Mather to come back and comment on that.

Dr. MATHER. Dr. Rowland, as you may recall, last September we filed with both the House and Senate Veterans' Affairs Committees a report that was requested of us as to the extent of our activities in hospice care and the care of the terminally ill. In that report we pointed out that we have a modest effort in this regard. It is key in the area of hospice care, that, whatever is done recognizes there's an inpatient palliative care unit with a home health support program. So where we already have established hospital-based home care programs, for the most part, those facilities have a better organized hospice care program.

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That is not to say that any hospital in the VA medical center system isn't giving special attention to those of the terminally ill. They are, indeed, doing so.

In the context of a hospice program and those programs that are accredited by the Joint Commission on Accreditation of Hospitals, there is evolving the particular configuration of a hospice program that we're further looking into, and ways we can foster those particular programs more adequately.

Dr. ROWLAND of Georgia. I am certainly pleased to hear that, and may I commend you in proceeding in that area. Because you know as well as I that that is a group of people that have a special problem and that if they're in an evironment where they can receive special attention for that problem, it is much better than being in a general hospital environment or even in home health care.

You raised that point, and I had raised that before, about the VA moving in that direction towards more home health care as a way to help address some of the Gramm-Rudman problems that we're experiencing. So I urge you to look at those areas, as you have been doing, and see if you think it will be better from the standpoint of the veteran and also from the standpoint of the constraints that we're under now to move into those areas more vigorously.

Thank you, Mr. Chairman.

Mr. PENNY. Any further questions from subcommittee members?

Mr. MONTGOMERY. I want to thank our witnesses this morning.

On the aged patient, Mr. Chairman, I think we should take the lead as a group. As I go across the country now, it seems like a lot of us are getting older. If we could help out not only our veterans, but if we could maybe be a leader to other groups with our facilities. I would just like to stress today, Dr. Gronvall, that we can get out there in front and help all Americans and win some more Nobel prizes and so forth, because we've got the research, we have the different geriatic clinics we're working with now. I think we could really do a great service not only to the veteran but to all mankind, as we gather this information and give the proper example.

You think now when you put an older person in a nursing home, that the individual stays there until they die. I was told, when I was out looking at the Veterans Hospital in Wadsworth, that they're working to take these people out of the nursing homes and send them home, and an increasing percentage is showing up in some of our nursing homes across the country. That's where we can get out in front, that's what I would like to see us do, as chairman of this committee, is to work in areas like this, to help all Americans.

Dr. GRONVALL. Mr. Montgomery, we very much appreciate that comment and your support. You remarks are exactly consistent with what we're attempting to do.

I think it does bear repeating, that if you look at the age distribution of American veterans, the curve, of course, mirrors the aging of the entire population, but the aging of the veteran population comes about a decade in advance of the aging of the general population. That, of course, is a feature of the large number of World War II and Korea era veterans. It is very appropriate for

the VA to be in a leadership position because we're facing the issue and it really should be described as an opportunity and challenge first and that the rest of the country very rightfully can learn by watching what we do. We will make some mistakes, and the country can learn from that. But we'll find some new and, we hope, imaginative ways with the help of this committee of meeting that challenge. So we very much appreciate your comments.

Mr. PENNY. Dr. Rowland.

Dr. ROWLAND of Georgia. I want to follow up on that and commend the chairman for those thoughts, because we do have some problems with our health care delivery system in this country.

I had had some discussions with the previous head of the Department of Medicine and Surgery in the VA about the VA being a prototype for delivery of health care to people in this country who could not afford the health care. It seems that we're going to have a two-tiered system and I think the VA could provide some leadership in that area.

Dr. GRONVALL. Thank you.

Mr. PENNY. If there are no further questions, I want to take this opportunity to thank Dr. Gronvall and his associates for their testimony this morning and for answering any questions that we presented to you.

With that, we will excuse this panel and call forward Jerry Stewart, president-elect of the National Association of State Veterans Homes. It is my understanding that Mr. Steward is accompanied by Jack Dack, chairman of the legislative committee.

Mr. Stewart, if there are others who are joining you at the witness table, we would appreciate it if you would introduce them for the record, and then proceed with your testimony as you wish. The entire written testimony will be included in the committee record.

STATEMENT OF FREDERICK TRAILL, CHAIRMAN, NATIONAL ASSOCIATION OF STATE VETERANS HOMES LIAISON COMMITTEE; ACCOMPANIED BY JERRY J. STEWART, PRESIDENT-ELECT, NATIONAL ASSOCIATION OF STATE VETERANS HOMES; AND JACK J. DACK, CHAIRMAN, NATIONAL ASSOCIATION OF STATE VETERANS HOMES LEGISLATIVE COMMITTEE

Mr. TRAILL. Mr. Chairman, my name is Frederick Traill. I am the Commandant of the Michigan Veterans Facility in Grand Rapids, MI. I am stepping in for Mr. Stewart today because he has laryngitis and felt he could not deliver the testimony.

With me today, on my left, is Mr. Stewart, the president-elect of the National Association of State Veterans Homes and the Commandant of the Sulphur, Oklahoma Veterans Center. On my right is Jack Dack, the Commandant of the Iowa Veterans Home and Legislative Chairman of the National Association of State Veterans Homes.

We have submitted our written testimony and request that it and our oral testimony be made part of the permanent record of this hearing.

Mr. PENNY. Without objection.

Mr. TRAILL. Thank you, Mr. Chairman.

We thank you and your fine staff and the staff of the full committee and the Veterans' Administration for your assistance in adding back some $20 million for the State home construction budget in the President's proposed fiscal year 1987 budget. We strongly support the extension of the construction grant program and would hope that you would consider a greater than 3-year extension.

We are extremely pleased that the committee, as stated in your discussion draft, wants to further increase construction funds to $50 million in fiscal year 1987. We feel that this increase will assist in reducing the backlog of projects currently awaiting funding.

As you know, Mr. Chairman, presently there are 34 States with State veterans homes. There are six States which have expressed some interest in establishing a State veterans home. The remaining nine States have exhibited little or no interest in establishing a State veterans home program. While we recognize the need to encourage new States to come in line with new programs, we have serious reservations about the concept of prioritization as expressed in your discussion draft of April 11, 1986.

In our view, other construction of State veterans homes would become a Federal initiative at the precise time when the emphasis in Government is cooperation and enhanced partnership between the States and the Federal Government. We, the State veterans homes, are the pioneers in the arena of long-term veteran health care.

The procedures in the discussion draft would work effectively in the short term to resolve the problem of new States coming into the program. In our view, it does little to encourage States already in the program to effectively plan for long-term expansion of capacity, remodeling and/or renovation, to meet life safety standards or other regulatory requirements.

Last year, in a letter sent to Chairman Montgomery, at the request of subcommittee staff, we answered a question raised on the discussion draft which eventually became House Resolution 505 as to whether "...we could support a division of the construction grant appropriation into separate pcokets for (1) funding of new homes in new States, and (2), funding the correction, renovation and expansion of homes already existing." We concurred in this approach but note that the concept did not appear in the language adopted by the subcommittee and forwarded to the full committee. We also note that our suggestion is not included in your discussion draft of April 11, 1986. We would like to submit, for the record, a copy of the above mentioned letter.

Mr. PENNY. Without objection.

[The requested letter appears on p. 85.]

Mr. TRAILL. We would find the discussion draft more acceptable if you, one, actively support funding of the levels identified in the draft, and two, create two lists of funding recommendations, one being for new homes in States not currently providing State home services, and a second list for States desiring to improve or expand

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their facilities. Within each list the National Association supports continuation of "first come-first served" prioritization.

As for the one-third rule, the Association narrowly voted to oppose removal of that limitation.

As we have stated in ou written testimony, increased funding for State construction projects will be a step in the right direction. However, it is imporant that the per diem rates which are prescribed by the law reflect the same consideration. Both sections of the program, construction and per diem, must walk hand-in-glove for the capacities to exist in the States to absorb the additional workload which will result from both the shifting of service from the Veterans' Administration and from the aging of the veteran population in the States themselves.

Appropriate levels of funding in both programs must be maintained to encourage those States currently providing veterans home services to retain and expand these services as well as to encourage additional States not currently providing State veterans homes to get into the program.

Appropriate levels of per diem funding can only be maintained through an annual rate review mechanism such as already exists for the VA nursing care programs and the community contract nursing homes. We also state in our written testimony that we fervently oppose a move to combine the Office of Geriatric and Extended Care with an Office of Clinical Affairs. This combination would skew to acute care orientation to the detriment of millions of aging veterans.

Mr. Chairman, we appreciate this opportunity to come here from Iowa, Michigan and Oklahoma to testify before you. We look forward to working closely with you and your staff to improve an already successful, cost-effective and vital program.

Thank you.

[The prepared statement of the National Association of State Veterans Homes appears on p. 88.]

Mr. PENNY. Thank you for your testimony.

I assume you will be speaking for Mr. Stewart on the answers to questions as well, or Mr. Dack may step in to answer questions on Mr. Stewart's behalf.

Mr. TRAILL. Yes, Mr. Dack or myself.

Mr. PENNY. What is the medium that the National Association of State Veterans Homes uses to encourage States which do not have a State home to enter into the program?

Mr. DACK. Mr. Chairman, being a member of the committee, along with Mr. Stewart, that works with new homes, we spend time in telephonic conversation with them. We have representatives from States without homes that attend our National Association meetings. We have staff who travel to these other States to meet, upon request, with community members within that State, or interested veterans' organizations or executive branch personnel, to discuss the development of a State home.

It has been our experience that, with a State that expresses an interest in establishing a State home, that it takes anywhere from 5 to 15 years before that becomes a reality, from the time the first germ of planting commences. It is a long, tedious process. For example, we have worked with the State of Florida since 1974. We

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have worked with the State of Hawaii off and on for the last 8 or 10 years. So it is handled through this process.

Also, we receive quite a bit of correspondence from some of these States from around the country that we submit information as to statutes, how you develop a home, and how a home is financed and so on.

Mr. PENNY. Chairman Montgomery.

Mr. MONTGOMERY. Thank you, Mr. Chairman.

To follow up, your association will help States such as mine, who recently became eligible, where the legislature put up the matching funds, you will go to the State or send them information? How does that work?

Incidentally, you and I talked this morning when I saw you earlier.

Mr. DACK. Mr. Chairman, all that has to be done is your State requests information from our Association, and through our Association we will provide whatever information they would like to have and how we have carried out our program, offer suggestions on how they might be able to establish a program, how to contact the Veterans' Administraton and so on and so forth.

Mr. MONTGOMERY. Do you have any veterans State nursing homes that are run by a private contractor, where you just contract the work out—the State just contracts out to run the nursing home? Does that take place in any other States?

Mr. DACK. I believe in the State of Georgia they have a contract with the medical school, that provides some supervision in that arena. How much, I don't know. But that's a question we could find out for the committee.

Mr. MONTGOMERY. I just wondered if that was done by some State veterans nursing homes.

Mr. TRAILL. Mr. Montgomery, I believe the State of Maryland has a similar approach. It seems to me they have a contract manager and one or two other people on the State payroll. They actually administer contracts—with whoever, I don't know—to provide services at the home.

Mr. MONTGOMERY. I am informed by counsel that Maryland uses a contracting firm from Pennsylvania.

It takes a long time for other States who are looking toward getting a State nursing home to realize one, we in Mississippi have been looking for 5 or 6 years. I do know that Alabama and Florida and some others are vitally interested in getting a State nursing home.

My last question. I assume you would highly recommend this approach of taking care of the aged veteran, that the State veterans nursing home has worked well for you?

Mr. DACK. Yes, and we think it works exceptionally well and it is a cost-effective alternative.

Mr. MONTGOMERY. Thank you.

Mr. PENNY. Mr. Dack, given your testimony about the delay involved because of a backlog of construction grants, do you believe the proposed amendment will be of great, modest, or no assistance in dealing with that problem?

Mr. DACK. Mr. Chairman, we have some concerns on some of the language within the bill, but we would like to work with the com-

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mittee on it. However, with the level of funding, and as we indicated in our oral testimony, we believe that we can set up a two-tiered system in which we can fund these new homes for States that do not have a home and want to develop a home to come on line earlier. We have some ideas about that and we think that would be practical.

But again, the problem has never been the process of how you award the grants. It's always been that the program has been underfunded for the amount of activity.

Mr. PENNY. But a modification that would allow States which don't already have a facility to be prioritized separately would certainly provide some encouragement in that regard.

Would you then have those two priority lists joined and a third list developed that would actually determine where the money goes. A list that would allow some new construction in States that haven't been under the program before, as well as construction in States that have been under but have demonstrated a need that would rank them perhaps above the new States coming on line?

Mr. DACK. The way we would visualize the approach we have suggested is, number one, at the present time there are 70 projects waiting to be funded at the Federal level. Out of those 70 projects, there are three States who do not have a veterans home. This is Mississippi, Florida, and Alabama. They are on the list awaiting funding. This funding they are requesting amounts to a little over $11.7 million.

It is our recommendation that out of the funding that's being requested, the $50 million, that those homes be funded up front and that the rest of the projects would fall in line on a first come. first served basis for the rest of the moneys.

Mr. PENNY. After that.

Mr. DACK. Right.

Mr. PENNY. So there wouldn't be a kind of merging of the two lists and a new priority established.

Mr. DACK. No.

Mr. PENNY. It would be up-front funding for those States which do not now have a facility and priority-based funding, first come, first served, for those States that are coming back either for extensions, expansions, or other new facilities.

Mr. DACK. Yes. You are only talking about six States at the present time who have demonstrated an interest, and three of those I have mentioned. So we feel this would be a way to bring more States into the program to provide the incentive for them to come aboard.

Mr. PENNY. I appreciate that. Thank you, Mr. Dack.

Mr. Rowland, do you have any questions of this panel?

Mr. ROWLAND of Connecticut. Just one quick question. Also built on that so-called grandfather clause you're discussing, wouldn't it also pertain to any applications previous to October 1?

Mr. DACK. I don't believe I understand what you're asking, sir.

Mr. ROWLAND of Connecticut. In talking about the first come, first served basis, where would be the cut-off point?

Mr. DACK. The cut-off point?

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Mr. ROWLAND of Connecticut. In reference to those six States you referred to that don't have homes now, but also as to applications pending.

Mr. DACK. Well, the applications pending should continue on a first come, first served basis. However, the new States who do not have a veterans home would be up front. They would be funded off the top. The rest of the States would fall in behind that on a first come, first served basis.

Mr. ROWLAND of Connecticut. Okay, thank you.

Mr. PENNY. Counsel?

Mr. FLEMING. Mr. Dack, what is wrong with the VA making the decision on a "most needs" basis? In other words, if I understand what you're saying, if Florida, Alabama and Mississippi and some of those come in, you would fund those up front and let everything stay the way it is. But there may be a need to establish three homes in Florida in order to meet the demand for nursing care in the State of Florida.

I guess the question I would ask is, what is wrong with their being a basis to where the States most in need, if they've got an application in, should be funded ahead of some of the others? Simply because you put one nursing home in a State doesn't necessarily mean that you have taken care of the situation that State.

Mr. DACK. That's understandable, Mr. Fleming. The basis and the success of the State veterans home program, in working with the States, has been predictability. If a State is not going to have some reassurance once they file an application, if they do not have the assurances they're going to receive funding, it is going to be a deterrent. If they're going to have to operate without knowledge, then I believe it will not serve as an incentive for the States already on line. The States will not want to do that.

So it is my feeling that the first come, first served allows a State to plan to mesh State funding with Federal funding, so they arrive at that mutual date together on increasing the bed capacity in a home or developing another new second home, or renovation or construction, whatever it might be.

Also, when you look at the list of projects, about 66 percent of the projects awaiting funding right now in the VA system—and they only take about 34 percent of the moneys—are involved with life safety, renovation of existing facilities, and so on and so forth. So if you put all of the funds into bed producting, or all of the funds into one State for bed producing, you've got other States over here that are going to lose beds because they don't meet regulatory requirements and so on. This has to be a blended program.

Mr. FLEMING. Well, you would have to give priority to projects that need to be updated to take care of code violations. You don't want veterans in substandard nursing homes. That's the reason 60 percent of the appropriation goes to updating existing facilities. Priority must be given to existing State home facilities. There's nothing wrong with that. It's for safety reasons.

Mr. DACK. Well, from the vantange point we view, and from discussions with the States, they feel this is the more equitable and predictable way of doing it.

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Mr. FLEMING. Why not grandfather projects already in the pipeline so there would be no adverse impact on those projects. The new procedure would apply to new applications.

Mr. DACK. I understand.

Mr. FLEMING. The State Home Program is a very popular program. I think all the Members agree that it's probably one of the more popular federally funded programs that we have. The benefits flow to both the Federal and State governments. That is the strength of the program. We hope to maintain the appropriation at the $40 million level for several years to take care of projects already in the pipeline.

Mr. DACK. We appreciate that, because this new home concept which we have just brought about is based upon that extra funding that has been pumped into the program. That's what has made it possible to do that.

Mr. PENNY. Mr. Rowland?

Mr. ROWLAND of Connecticut. If I may just follow up. Let me, if I can, state where I think you are on this. You do favor the first come, first served basis, but you want to take care of those particular States that don't have State homes, and you don't necessarily support the so-called priority system.

Mr. DACK. That is true. What we're saying is that a State that does not have a State home, with the funding they would come right off the top. Then all the rest of the projects, the States who already have homes within them, or they want to build a second home, or they have remodeling or renovation, they would follow on a first come, first served basis for the predictability of the program for the State to be continued to be interested, to continue to mesh State moneys with Federal moneys.

Mr. ROWLAND of Connecticut. Thank you.

Mr. PENNY. Thank you for your testimony.

We'll excuse this panel and call forward the next panel, which will include Mary Stout, secretary of the Vietnam Veterans of America. It is my understanding that she is accompanied by Mr. Richard Weidman, Director of Government Relations. This panel will also include Paul Egan, Deputy Director, National Legislative Commission, the American Legion, and he is accompanied by John F. Sommer, Jr., Deputy Director, National Veterans' Affairs and Rehabilitation Commision.

If you would present your testimony, beginning with Miss Stout, be assured that your entire written testimony will be included in the committee record and you are free to summarize as you wish.

With that, I also want to turn the Chair over to the chairman of the full committee, Mr. Montgomery, for a few minutes while I step out to visit with some constituents.

Mr. MONTGOMERY (presiding). Miss Stout.

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STATEMENTS OF MARY R. STOUT, SECRETARY, VIETNAM VETERANS OF AMERICA; ACCOMPANIED BY RICHARD F. WEIDMAN, DIRECTOR OF GOVERNMENT RELATIONS; PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION; ACCOMPANIED BY JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

STATEMENT OF MARY R. STOUT

Ms. STOUT. Mr. Chairman and members of the subcommittee, on behalf of Vietnam Veterans of America it is my pleasure to be here to present our views on the issues before the committee today, particularly legislation concerning the continuation of the Veterans Readjustment Counseling Program, and the health care amendments for veterans for 1986.

It is the belief of our organization, as stated in our declaration of principles, that military service is an obligation of citizenship. This should not be viewed as a stepping stone to lifelong benefits or a particular status within the American society. It is the commensurate obligation of this society to ensure that the individual who has served is not lessened as a result of that service.

Some have said that readjustment for Vietnam veterans is over. Last week I had the privilege of listening to Col. John Ripley, who is a Marine Corps Vietnam combat veteran and presently professor of english and history at the U.S. Naval Academy, talk about those he served with in Vietnam. He talked about the Marines, the troops, the ground troops, and what had happened to them, the casualty rate, the percentage of casualties.

One of his statements struck me as particularly appropriate to what we are considering today. It has to do with psychological wounds. I would like to quote from Colonel Ripley, when he said there is a 100 percent chance, an absolute certainty, that those who served on the ground in Vietnam suffered psychological wounds. Many still bear these wounds. These are veterans who have struggled for years with the aftermath of the war in Vietnam. The continuation of the Veterans Readjustment Counseling Program is necessary. He needs to be provided for through separate facilities. I believe that you will come to understand this based on our testimony today and the testimony of the other veterans' organizations that are here.

With me today is Richard Weidman, who is our Director of Government Relations. He is also our representative to the Veterans' Administration Advisory Committee on Vietnam Veterans Readjustment. Earlier this year the Veterans' Administrator named him vice-chairman of that important committee. Mr. Weidman will present our views in depth on the issues we are considering.

[The prepared statement of Mary R. Stout appears on p. 114.]

Mr. MONTGOMERY. Mr. Weidman, your full statement will be put in the record, without objection. You can summarize or proceed in the manner you prefer.

STATEMENT OF RICHARD F. WEIDMAN

Mr. WEIDMAN. Thank you, Mr. Chairman.

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I listened earlier this morning to your opening remarks, Mr. Chairman, and would offer a somewhat different viewpoint, with all full and due respect, sir. VVA very much does favor enactment and passage at this time of H.R. 4623, for a variety of reasons.

The first is, Mr. Chairman, we believe that the preponderance of evidence already exists that the need for psychological counseling will, in fact, continue beyond September 30, 1988. The Congress, of course, has recognized that in the enactment last session of Public Law 98-160, which removed any time specific entitlement to readjustment counseling for any Vietnam era veteran who shall request it.

The Legion and our good colleagues over at the American Legion, in a study that they did last year, indicates there are significant long-term problems even among veterans who are gainfully employed, and who otherwise on the surface seem well adjusted. Many, many veterans are having significant life difficulties that beg for readjustment counseling.

In this regard as well, I would point out and draw your attention specifically to appendix I of our statement today, which shows that the Vet Center usage is by no means declining. I would remind you, Mr. Chairman, and members of the committee, that harking back to 1979 in the legacy study which was mandated by the Congress, it was estimated that roughly 850,000 Vietnam veterans would be in need of psychological counseling, readjustment counseling, and this need would take the form of a bell curve. If you look at that appendix, you will see that we are now at just about 400,000. We are approaching the top of that bell curve and there is no reason to believe that 6 years into the program we can get down the other side of that bell curve in the next 2 years.

Frankly, Mr. Chairman, we would like to see a mandated extension of the Vet Center system. We are, however, cognizant of the arguments that we need to wait for the RTI study that is mandated, that is due next April 1 even though we think that the chances of it being delivered on April 1 or, indeed, even by September 30 of next year, are very slim. That is not due to any malfeasance on the part of the VA or the contractor, but simply just the difficulty they've had in coming through with study results that make some sense.

The middle course that has been proposed by Mr. Edgar, which does not mandate continuation of the system but merely eliminates the need to start to dismantle the system as of September 30, 1987 is, in fact, a judicious and reasonable middle course. What it does is preserve an option so that the system does not begin to be dismantled and then cost us a great deal more money to come back and try and find an alternative.

The reason why we believe this is the right time to make this is—the analogy that we would use is the one the Honorable Marvin Leath demonstrated, with strong support from Chairman Montgomery, the need for an employment program, so that led to the enactment of Public Law 98-77. When it came time to renew that, everyone was waiting for the Centaur study to be delivered and for the results of that to be digested.

Everyone waited for the results of that study. By the time it was recognized that the needs continued, and the committee was able

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to act and convince your colleagues over on the other side of the hill that there was a need to continue that program, we were out of phase with the funding cycle. It has taken a great deal of difficulty and we still have not achieved proper funding that would enable the Veterans Job Training Act to continue today.

We are extremely worried, Mr. Chairman, that we will end up in essentially the same bind with the Readjustment Counseling Service, which is literally, in our view, a life and death situation. The average Vet Center does 9 hours of after-hours crisis intervention per week, which amounts to 50 FTEEs a year. What that means to the communities across America and being able to have that kind of service in their community is just enormous.

Mr. Chairman, there were a number of other comments I wanted to make, but that was the initial statement. I see that I am out of time and I don't want to run over. Thank you.

Mr. MONTGOMERY. Thank you very much for that very excellent testimony.

Mr. Egan.

STATEMENT OF PAUL S. EGAN

Mr. EGAN. Thank you, Mr. Chairman. John Sommer will summarize our remarks.

But, before turning the microphone over to him, I think it would be appropriate to compliment you on some of your earlier statements in which you point to the fact that what happens to elderly veterans is ultimately going to happen to all Americans. In that regard, I think a few statistics are in order.

By the year 1990, 2 out of every 3 males in this country who are over 65 years of age will be veterans. At the same time, the VA has chosen this particular time to accelerate its reliance on the private sector, which we feel is a bit premature at this particular point. That is especially true given the fact that currently there are only 19,000 nursing homes in the country providing 1.4 million beds in the private sector. An additional 1.2 million more nursing home beds wil be needed by the year 2000 according to HHS.

So what that suggests to us is, first of all, it's premature for the VA to begin relying more heavily on the private sector. The private sector is currently, and can be expected to continue to be, ill-equipped to address the needs of not only veterans but all Americans for the foreseeable future. In that regard, it is probably also premature for the VA to be considering eliminating the position of Assistant Chief Medical Director for Geriatrics and Extended Care.

Mr. MONTGOMERY. Thank you for pointing that out. We are concerned about that situation and our committee will look into it.

Mr. Sommer.

STATEMENT OF JOHN F. SOMMER, JR.

Mr. SOMMER. Thank you, Mr. Chairman. Because of the number of issues under consideration today, I will limit my remarks to just a few of the proposals.

The American Legion feels that the findings of a pilot program to provide autonomous fiscal management to five medical center directors could provide some very useful information, particularly at

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a time when the VA is faced with an austere medical care budget. We would recommend that the language in the proposal clearly state its intent so as to alleviate any possibility of a misunderstanding that could impact negatively on the provision of medical care to veterans.

We are also very much in favor of the amendment to section 610(a) of title 38, to make respite care a permanent program.

We are supportive of the proposal to eliminate the September 30, 1988 date by which the transition of the Vet Center program in the VA medical care facilities is to be accomplished.

In our full statement we mention some of the initial findings of the Columbia University and American Legion Vietnam Veterans study. We submit these findings to emphasize the concerns of the American Legion that a number of Vietnam veterans, many of whom seemingly made a successful transition from military life back into civilian society, have later manifested varying degrees of psychological and socioeconomic distress. Other veterans have never totally completed their post-Vietnam recovery and readjustment processes. The Vet Center program continues to be a major factor in the treatment of Vietnam veterans with diagnosed post-traumatic stress disorder, others with identifiable symptoms of PTSD who do not meet the DSM-3 criteria, and also in providing counseling, crisis intervention, and numerous other services to Vietnam veterans.

Because of the obvious need for these valuable services and the continuing influx of Vietnam veterans seeking assistance through the Vet Centers, the American Legion supports the extension of the Vet Center program for as long as there is a demonstrable need for these services.

Mr. Chairman, that completes our summary.

[The prepared statement of the American Legion appears on p. 146.]

Mr. MONTGOMERY. Thank you.

Mr. Rowland?

Mr. ROWLAND of Connecticut. No questions, Mr. Chairman.

Mr. MONTGOMERY. I don't believe I have any questions. I appreciate your testimony.

I would just repeat that, as chairman of the full committee, I have a responsibility to put some priorities on some of these programs. I am just concerned that if we move too fast and implement new programs and extend programs, when it's really not necessary, I think it makes more logic and more sense to wait and see where we're coming from.

As I said earlier, we haven't even gotten a budget yet for fiscal 1987. We think we came out pretty well under the 1986 budget, considering that some other programs and departments have been devastated. They can't make it under Gramm-Rudman. At least we can make it. So we have all got to pull together here, the veterans organizations as well as this committee, to see that our key programs are protected and that the veterans are treated fairly. That is really basically where I'm coming from.

Thank you, Mr. Chairman.

Mr. PENNY (presiding.) Thank you, Mr. Montgomery.

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I don't have any questions of this panel. I do want to thank you all for your testimony. With that, you may be excused and we will call forward the last panel for this morning's hearing.

This panel will include David Gorman, Assistant National Legislative Director for Medical Affairs of the Disabled American Veterans; Dennis Cullinan, Special Assistant, National Legislative Service, Veterans of Foreign Wars; and Dennis Smurr, Associate Legislative Director of the Paralyzed Veterans of America.

As you know, gentlemen, your entire written testimony will be included in the committee record, and you are free to make your remarks or summarize your testimony in any way you wish. Feel free to proceed in the order I introduced you. Mr. Gorman, that would put you first.

STATEMENTS OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS; DENNIS M. CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND R. DENNIS SMURR, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you very much, Mr. Chairman. It is, indeed, a pleasure to be here this morning.

In our written testimony we cover in some detail the issues that are pending before the subcommittee today. In summary, though, I would like to hit on just a couple of those issues that are of particular concern to the Disabled American Veterans.

First I would like to comment on the draft legislation proposed by Chairman Montgomery that would basically propose to promote efficiency within the management of VA medical centers on a pilot program. As we understand it, five VA medical facilities would be designated to participate in the pilot program wherein the directors would have the authority to either waive or alter existing laws and regulations and other constraints concerning management and administrative issues. In essence, they would be given broader latitude in the day-to-day functions of their facility.

It is our impression, however, that all laws and regulations governing veterans' eligibility to receive VA health care and health care services would remain intact. In that vein, Mr. Chairman, we would suggest that, if enacted, the intent of this measure be closely scrutinized and report language to that intent be carefully set out.

With regard to the provision of respite care, we recognize that this is a relatively new method of treatment in long-term care. We certainly support the VA's authority to provide respite care as provided by this measure.

With respect to H.R. 4623, Mr. Chairman, it is our opinion that this bill proposes, through appropriate amendment to title 38, to remove that provision of law requiring the transition and integration of readjustment counseling services into existing medical facilities by October 1, 1988. It is our view that this measure would, in effect, establish Vet Centers as permanent, separate entities within the framework of the VA health care system.

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Mr. Chairman, there has been much discussion this morning about the report and the study that the VA is currently undertaking and will submit to Congress. We do oppose this provision of H.R. 4623 simply based on the fact that we think it is extremely premature to delete the transition date of October 1, 1988. We would be more than glad to review the results of that study when they are available and at that time rethink our position. But for the time being, we do think that passae of H.R. 4623 is premature.

With that, Mr. Chairman, I think I will conclude my remarks.

[The prepared statement of David W. Gorman appears on p. 157.]

Mr. PENNY. Thank you, Mr. Gorman.

Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you, Mr. Chairman. On behalf of the Veterans of Foreign Wars I would like to thank you for the privilege of appearing here today so that we may present our views on the proposed legislation which would refine the VA health care delivery system's ability to enhance its educational and service delivery capabilities.

Proposal 1 would change the calculation of employment time owed the VA for part-time students under the VA's Health Professional Scholarship Program. This change would require 6 months of full-time VA employment for each calendar year or part of a calendar year of scholarship support. The VFW favors this proposal inasmuch as it would provide a fair and easily-administered system of reimbursement for VA scholarship aid. We would point out, however, that this may tempt participants in the program to keep their credit load just below a full-time level in order to obtain almost a full education for only a partial obligation of service to the VA.

Proposal 2 would make permanent the VA's Continuing Medical Education Program and also clarify certain aspects of the Regional Medical Education Center Program by allowing joint sponsorship of training programs, joint sponsorship of students, nonresident training, and training for other than direct health care providers.

The proposed legislation would also liberalize the restrictions on how training is carried out and for whom. The VFW supports this liberalization inasmuch as it would allow for enhanced training methods and for training essential members of the Department of Medicine and Surgery, such as engineers, housekeeping personnel, data processors, food handlers and so forth.

The VFW also favorably notes a technical clarification contained in this proposal calling for full reimbursement for participation in RMEC programs by non-VA personnel. This would enable the RMECs to extend training opportunities at non-RMEC locations to community participants without incurring any additional costs. Thus, this legislative initiative enjoys strong VFW support.

Proposal 3 would extend for 3 years the authority of the VA to enter into contracts with the Veterans Memorial Medical Center in the Philippines for care of U.S. veterans. We believe that this veterans medical center is, in fact, about the best medical facility

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available in the Philippines and the VFW therefore supports this proposal.

Proposal 4 would make more flexible the authority of the VA to share medical facilities, equipment and information with community facilities. We favor this proposal since it would not only lead to a beneficial exchange of information between the VA and the medical community at large, but also represents a cost-effective means of providing certain medical and laboratory capabilities not always available through the VA at a given location.

Proposal 5 would clarify the VA's authority to provide respite care services. We view this proposal as a compassionate step for both the veteran and his family. We would point out that respite care is not only often the best form of health care by providing the best aspects of institutional and home care, but it is also cost effective. Many veterans would end up permanently institutionalized instead of only temporarily occupying a bed at a VAMC without this form of care. The VFW thus supports this proposal.

Proposal 6 would be supported by the VFW, since it would extend for 3 years the program for grants to States for construction, remodeling or renovation of State home facilities and would also liberalize the application approval process. The VFW has stated in previous testimony that increasing the funding for this program would assist the VA in reducing the number of basck-logged applications on hand from the States and should, most importantly, result in more extended care beds being available sooner.

Proposal 7 would amend the procedures for disciplinary boards and grievance procedures for title 38 employees. Although the VFW has no objection, per se, to refining the VA's disciplinary process and procedures, we would point out that disciplinary boards and grievance procedures for title 38 employees have been very effective over the years. They have provided due process while delivering, in our opinion, sound decisions. Therefore, we can only recommend extreme caution in the implementation of this or similar proposals.

Proposal 8 would clarify the authority for a VA medical facility and a DOD military unit, or DOD medical facility, to enter into a VA/DOD sharing agreement. As we have stated in previous testimony, the VFW believes that such arrangements may well benefit both the VA and the military.

Proposal 9 would extend to 4 years the interval for the VA to report on special pay comparability for VA physicians and dentists. Our medical consultant has informed us that such an action would be totally appropriate and we therefore support this proposal.

Proposal 10 would delete the requirement for transition by September 30, 1988 of the Readjustment Counseling Program, from a program primarily of storefront services delivery to services delivered primarily through VA health care facilities. These Vet Centers serve an especially vulnerable and deserving segment of the veteran population. Vet Center usage has been increasing by approximately 1,600 new clients a month. So it is evident that the need for readjustment counseling is increasing. Therefore, we support this proposal, which would appropriately make this particular service delivery component a part of DM&S's structure.

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Proposal 11 would authorize the creation of a Vietnam Veterans Readjustment Counseling Professional Fellowship Program. This fellowship program is to assist in providing an adequate supply of trained professionals to furnish readjustment counseling services to veterans. The VFW supports this proposal.

That concludes my statement, Mr. Chairman.

[The prepared statement of Dennis Cullinan appears on p. 163.]

Mr. PENNY. Thank you, Mr. Cullinan.

Mr. Smurr.

STATEMENT OF R. DENNIS SMURR

Mr. SMURR. Mr. Chairman and members of the subcommittee, I am Dennis Smurr, Associate Legislative Director for the Paralyzed Veterans of America. On behalf of the members of PVA, it is my pleasure to present to you our views and concerns regarding the legislative proposals being discussed today.

Our comments will center upon those issues of respite care, the proposed revision of State home construction program grants, and the pilot program to encourage efficiency and economies within certain VA medical centers.

Before going into the specifics of the above-mentioned proposals, PVA would like to commend the subcommittee for its leadership in trying to improve both the quality and delivery of what we consider to be the most important benefit provided veterans—that of adequate health care. No other veteran benefit better symbolizes this country's commitment and concern for the welfare of those who answered the call of duty in defense of the ideals of this great nation. No other veteran benefit carries with it the enormous investment in physical facility and human workforce, all of which benefits not only the veteran it is designed to serve, but also the economic well-being of the communities in which the VA facilities are located, and the overall viability of the nation's medical system. It is for these reasons and more that PVA seeks to secure through the Veterans' Administration the very best, the most compassionate, and the most comprehensive medical care services this grateful nation can provide.

In keeping with this goal, PVA is pleased to endorse the bill introduced by Chairman "Sonny" Montgomery to establish a 3-year pilot program, giving five VA medical centers increased latitude to test certain management initiatives, thereby improving the center's operating efficiency and economies. Hopefully, the savings realized by such management initiatives can be translated into improved medical care service for the veterans being treated, or to allow additional veterans a more timely access to the system. With more than 35,000 veterans currently being turned away from VA medical centers each month, the VA needs to be given the opportunity to try what is being proposed.

We hope that the efficiencies achieved with these studies will not be made at the expense of treating fewer veterans, or at the sake of reduced quality of care provided. We trust this will not be the case, but since this language is not specifically stated in the bill, we think it imperative that such a statement be included just to preclude such from happening.

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Even though we have the utmost repsect and confidence in the dedication of the VA hospital directors, we know, too, of the zealous glee and influence that the Office of Management and Budget has over the VA when it comes to matters of monetary savings.

Another apsect of the proposal which is of concern to us stems from the fact that no mention is made as to what happens to the savings that hopefully will be realized by this pilot program. We trust these moneys will not simply be channeled back into the U.S. Treasury, for to do so would provide little incentive to the individual hospital directors to really optimize the potentials inherent in this pilot program. PVA would encourage this subcommittee to add necessary language to the bill to ensure, given proper accounting, that any and all monetary savings realized under this program be set aside in a trust account for use by the individual VA medical center which realized such savings in order that they may further improve or augment the level or quality of care which they, in fact, provide their veteran patient clientele.

In reference to the "Veterans Health Care Amendments of 1986", PVA would like to commend Chairman Edgar for the inclusion of respite care in this bill. We have been a long and ardent advocate of the need for the VA to provide this most necessary and important service to veterans who, like PVA members, realize full well that the need for respite care is an ongoing and ever present necessity, not only for the individual, but equally so for the person or persons who provide the care.

In reviewing the definition proposed for respite care, PVA would encourage the subcommittee to consider adding hospital-based home care as another viable means of providing the type of assistance intended under this section. We would therefore suggest the following language change: "The term 'respite care' means intermittent or temporary hospital, hospital-based home care, or nursing home care provided to a veteran who has been diagnosed as suffering from a chronic illness or medical condition and who without provision of such care could face the prospect of having to be provided similar services only in an institutional, long-term basis, as determined by the Administrator."

This change would enable the VA to provide respite care in the veteran's home environment, therefore precluding unnecessary travel which for many vets with chronic disabilities is a difficult and expensive undertaking.

Another concern we have has to do with eligibility. We trust that the newly implemented means test will clearly define which veterans will be eligible for respite care services, although we do foresee some difficulty in assessing the cost of providing such service to a veteran. This, in turn, could make it difficult to determine program eligibility based upon a veteran's "inability to defray the expense of respite care."

PVA encourages this subcommittee to incorporate into the respite care proposal some language that will ensure the prompt and timely provision of respite care to a veteran when needed. The reason for making this request stems from our experiences in dealing with chronic medical conditions. It must be remembered that if respite care services are going to be provided, it is not the chronically disabled veteran who is in need of emergency medical treat-

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ment. It is a situation where the veteran's primary care giver is unable to provide the care. Therefore, we desire assurance that the veteran who seeks respite care will be given the same timely provision of service as that provided any other vetran who seeks medical assistance from a VA health care facility.

With regard to section 8, which seeks to make major changes in the VA's State home construction grant program, PVA is in full accord with the changes being proposed. We would suggest one minor technical change, and that is with regard to item two, section (C), which the language goes "the number of other facilities in the geographic area of the proposed facility that may be available to provide nursing home or domiciliary care to such veterans." We would prefer to have part (C) read: "the number of other facilities in the geographic area of the proposed facility that may be not only suitable and available but willing to provide nursing home or domiciliary care to such veterans;"

By the insertion of this qualifying terminology, the VA Administrator should be in a better position to determine the relative need of a given project based more upon the number of facilities which would actually be willing to provide care to the area's veteran population.

It is one thing to have such facilities in existence, but it is much more important to know that these facilities are, in fact, willing and able to provide the care that the veteran population is in need of at the time. We know all too well that many nursing homes are either of improper design or prefer to cater to a different clientele than the veteran, so we think it's imperative that these facilities not be considered as a viable resource.

In closing, PVA does support the extension of the VA authority to maintain a facility in the Philippines. With that, Mr. Chairman, I conclude my statement and would be happy to answer any questions you may have.

[The prepared statement of R. Dennis Smurr appears on p. 171.]

Mr. PENNY. Thank you, Mr. Smurr.

Mr. Gorman, in your testimony on page 3 you state that you perceive that H.R. 4623 would make Vet Centers permanent, separate entities within the VA health care system. Chairman Edgar's intent is only to give the VA management flexibility to close or not to close specific storefront Vet Centers based on need.

Will you comment on the differing interpretations of that provision?

Mr. GORMAN. Mr. Chairman, our reading of the proposal to virtually make that major change to section 612A does, in our opinion, infer that the Vet Centers would be made a permanent entity within the VA system, separate and apart from existing VA medical centers.

I want to say that the DAV certainly, in taking this position, has no preconceived notion or desire either to dismantle the Vet Centers as they currently exist or, for that matter, to preclude readjustment counseling services from being furnished to deserving and needy veterans. Simply, our feeling is that the measure, as proposed by Chairman Edgar, is simply premature at this time.

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Mr. PENNY. Are you satisfied that if there is a need in an area not served by a VA medical facility, that the storefront operation will be extended beyond the 1988 date?

Mr. GORMAN. Yes, sir. We have also said we believe there has been a need and there will continue to be a need for readjustment counseling services. But as a whole, if that situation you describe should arise, then we would think the VA should have the flexibility to maintain that storefront operation where the need is, if there was no VA medical center in close proximity.

Mr. PENNY. You don't feel that existing law has a bias against storefront operations?

Mr. GORMAN. No, I don't.

Mr. PENNY. Mr. Cullinan, in your testimony you embrace the proposal in Mr. Edgar's bill to use some existing funds for a fellowship program to train counselors. If you had to list all the things that you would like to see done with existing money, how close to the top of the list is the reallocation of money for this purpose?

Mr. CULLINAN. Well, if I were to construct such a list, clearly it wouldn't be up quite as high as providing top notch health care to veterans or maintaining the programs that are now in existence. In fact, the VFW precludes by our resolution moving moneys around—in other words, dismantling one program to fund another.

So, to answer your question, it would not be at the top of the list. No, I wouldn't want to see other programs undermined. But then again, we feel that shouldn't have to happen that way.

Mr. PENNY. I appreciate that. I just felt it deserved a little more elaboration.

I have one question for Mr. Smurr as well—not really a question, but just a comment. I certainly agree with the statement you made about using the savings at these medical facilities within those facilities to provide additional health care, rather than turning the savings back to the Federal Treasury. It seems to me that that accomplishes two objectives: first of all, it provides a real strong incentive to achieve whatever savings you can, because you get to use those savings locally, and secondly, it makes it very clear that within existing resources we're going to try to do our best to maximize and increase the delivery of health care.

For that reason, I want to make it clear to you that it is our intent to see that that language is added to the bill when we bring this bill up for markup. I intend to offer that amendment, and if you want to work with the committee staff and my staff over the next several days to prepare the proper language, we will be sure that that's taken care of.

Mr. SMURR. Thank you very much, Mr. Chairman.

Mr. PENNY. With that, I don't have any additional questions for this panel. We thank you for your testimony. And, since this is the last panel, the meeting will come to a conclusion.

[Whereupon, at 11:38 a.m., the subcommittee was adjourned.]

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APPENDIX

STATEMENT OF

JOHN A. GRONVALL

DEPUTY CHIEF MEDICAL DIRECTOR

BEFORE THE SUBCOMMITTEE ON

HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

April 22, 1986

Mr. Chairman, I am pleased to appear before the Subcommittee to present the views of the Veterans' Administration on pending legislation affecting the VA's health-care program. We appreciate your introducing, as part of your proposed Veterans' Health-Care Amendments Act, provisions that would generally carry out initiatives in VA's legislative program, enactment of which would assist VA in carrying out its mission to provide quality care to veterans.

Our views on the major proposals you are considering are as follows:

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EXTENSIONS OF AUTHORITY

EXTEND CONTRACT CARE TO VETERANS MEMORIAL MEDICAL CENTER IN THE PHILIPPINES

We strongly favor extending the authority to provide payment for care to U.S. veterans in the Philippines in the Veterans Memorial Medical Center and to make grants of up to $500,000 annually to the VMMC for replacing and upgrading equipment and rehabilitating its physical plant and facilities. Before and during the Second World War, thousands of Filipinos served in or with the United States Armed Forces in the Philippines. Many of these veterans were casualties of that War. This Country has consistently reaffirmed its moral obligation to provide medical care and treatment for these veterans.

In 1948, Congress authorized a five-year grant program to provide medical benefits to Filipino veterans, including the construction and equipping of a hospital in Luzon. That hospital, which is now the Veterans Memorial Medical Center, was turned over to the Philippine Government in 1955. However, Congress provided and regularly extended authority to VA to provide care to United States veterans in the VMMC and grants to that facility to continue the high standard of medical care to United States veterans.

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Although we believe that it has always been the clear intent of Congress that the Philippine Government should take full responsibility for the VMMC, we believe that the authority to provide grants to the VMMC, as well as authority to provide contract care to U.S. veterans in that facility should be continued. To terminate these grants now could jeopardize the operation of the VMMC and its ability to satisfactorily maintain its complex and replace and update essential medical equipment and supplies. Because of the need for VA assistance for these veterans, we also recommend that the authorities to provide contract care and grants be extended for an additional five years, through September 30, 1991, instead of three more years, as proposed in your legislation.

EXTEND STATE HOME GRANT AUTHORITY

VA endorses extending our authority to provide grants to States for the construction or acquisition of State home facilities for furnishing domiciliary and nursing home care, and for remodeling or renovation of State home facilities for furnishing hospital, domiciliary and nursing home care. This authority will expire at the end of this fiscal year. This important cost-sharing program makes it possible to extend medical care to veterans beyond that which can be provided in VA facilities. It is a cost-effective approach, with Federal

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participation limited to no more than 65 percent of the cost of any one project.

There are now State homes in 35 States. Nursing home care is provided in 45 homes, domiciliary care in 43 homes, and hospital care in seven homes. From Fiscal Year 1966 through Fiscal Year 1985, approximately $179 million was obligated in support of new nursing home care and domiciliary beds and for remodeling and modifying existing buildings. Eighty-three percent of the funds have been used for bed-producing projects. The remainder has been used for remodeling and renovation. The Budget request for this authority for Fiscal Year 1987 is $42.4 million, and $42 million for each of the subsequent years. Because of the importance and effectiveness of this program, we favor extending this authority for an additional five years instead of three years, as contained in the bill. However, we believe the amounts requested in the President's budget are sufficient to meet the needs of the State home program and recommend that the higher authorization levels contained in this bill be reduced accordingly.

We also favor the provision in your bill that would eliminate a limitation in law which provides that no one State may receive in any fiscal year more than one-third of the amount appropriated in that fiscal year for grants to assist States in the acquisition or construction of State veterans' homes.

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This limitation was enacted to prevent perceived abuses in the grant program. At the time, it was believed that a few States had received inequitably large grants. This limitation has not, however, prevented the approval of any State home grant request. Because Congress typically permits funds appropriated for State home construction grants to remain available for three fiscal years, a large grant can be funded from more than one fiscal year's appropriation. We proposed repeal of this provision as part of our legislative program because the only effect of this limitation is to delay approval of large State home grant applications until enough money to fund the grant can be accumulated from different fiscal years' appropriations.

REVISION OF STATE HOME APPROVAL PROCESS

Under existing law, the VA must approve a grant application if the VA determines that it meets the requirements of 38 U.S.C. § 5035. The statute has been interpreted to leave the VA with little room to rank grant applications according to priorities or relative need. As a result, the VA approves grants as funds become available in the order in which grant requests are received.

This legislation would change this procedure so as to provide for granting awards based on a "relative need" concept. The

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proposal would require the VA to determine the relative need for each State-proposed project in relation to all other grant applications received by the VA. After determining the relative need for a project, the Administrator would be given discretion to approve the amount of assistance applied for in whole or in part.

In addition, the proposal would require VA to submit each year to the Committees on Veterans Affairs of the Senate and House of Representatives a report on the grant program's operation including a list of states which submitted preapplications and the VA's recommendations as to the relative need of each preapplication.

This proposal would constitute a revision of a long-standing process, apparently intended to assure that State home construction grants are awarded on the basis of relative need as determined by the VA. There appear to be two major premises underlying this proposal. The first is that the existing program fails to address VA's need for State initiated projects. The second is that Congress must change this grant program in order to assure that grants are targeted to most-needed projects.

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Relative need for a project is already provided for to the extent that the law proscribes VA from approving a grant if construction of the project will result in more than 4 nursing home beds per 1,000 veterans in that state. Moreover, a state requesting a grant for a project which would result in more than 2-1/2 nursing home beds per 1,000 veterans in a state must provide sufficient justification for the VA to determine that the additional beds are required.

In our judgment, enactment of this proposal could discourage some states from applying for State home construction grants. Currently, if a state undertakes the expense of submitting a complete formal application (which could cost up to 10% of the projects cost), the law requires VA approval of the application as long as it meets the requirements of section 5035.

This legislation would eliminate that assurance of approval, and would permit approval, delay, or disapproval. Even if the Administrator determined, based on a project's grant pre-application, that the project's relative need were high, the state would be uncertain whether the project would be funded because the determination of need would be subject to reassessment and change at any time. In addition, the proposal would permit the VA to approve a funding request in whole or in part. Thus, a state which embarks on the costly process of

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applying for a VA construction grant would have no assurance of obtaining funding assistance in advance of obligating funds to obtain needed architectural plans and specifications, for example. Because of this uncertainty, we anticipate that some States would be less likely to plan and request funding for State home projects if this proposal were enacted.

We recognize that there may be criticism that the existing program does not give sufficient weight to relative need among State home projects. While we believe the current program has worked well for many years, we must acknowledge that this proposal would allow VA to target grant money to areas of greatest need, and could, therefore, encourage some non-participating States to submit applications. This could be a useful tool in assisting the VA to better manage its nursing home provider mix.

Although we believe it is premature to make any decision to change the current approval process at this time, there may be options such as that contained in the current bill, which would provide additional flexibility. More time should be allowed, however, to study all of the ramifications of these options before a change is made to the existing procedure.

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RMEC PROGRAM

We favor the concept of setting VA's Regional Medical Education Center (or RMEC) program on a more established footing. Existing law, as enacted in Pub. L. No. 92-541, contemplates that VA operate this program on a pilot basis. The bill proposes a number of changes. Among these, we favor the deletion of current statutory language which specifies that RMEC training be conducted on an "in-residence" basis. That language, if narrowly read, would appear to suggest that RMEC training must be conducted at the RMEC site. In many instances, it is more economical to conduct an educational program at a work site or other locale. In addition, current automated data processing and telecommunications advances offer extensive opportunities to enhance training availability and economy by permitting "remote" and simultaneous training opportunities to be presented to VA personnel in a fashion which obviates, or minimizes, the need and expense of employee travel and extended absence from regular duties for training.

We also support broadening the classification of VA employees who may receive RMEC training. Currently, the law specifies that RMECs shall provide education programs for "medical and health personnel" and thus could be read to imply that RMEC training will only be made available to direct-care providers, such as physicians and dentists. Other personnel, such as

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counseling psychologists and vocational rehabilitation specialists, are not technically classified as direct-care providers, but are often indispensible elements of VA's integrated health-care teams. In addition, other personnel who do not have direct treatment responsibilities, such as diagnostic equipment operators and medical records specialists, serve important missions in support of health care. Such personnel need occasional training that can be effectively provided through the RMEC program.

Finally, we favor providing the Administrator with the authority to enter into "sharing" or cooperative training agreements with public and nonprofit private entities. For many medical specialty areas, the number of VA employees who might need training within a specific RMEC region is too small, or employees are too scattered geographically, to permit economic instruction under RMEC sponsorship alone. In such instances, cooperation with other interested professional groups (who themselves might face inefficient economies of scale) would provide the means for economical training. We would note that section 5(c) of the bill does not clearly authorize VA to enter into sharing arrangements regarding training programs. VA staff will be glad to work with your staff to perfect this provision.

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PROVIDE AUTHORITY FOR RESPITE CARE

The bill would also authorize VA to provide needed "respite care" to veterans eligible for hospital or nursing home care. Respite care represents a relatively new concept for VA which we wish to evaluate on a pilot basis. In essence, "respite" care refers to providing brief periods of care in VA health facilities on a prearranged basis to chronically-ill persons in order to relieve members of the veteran's family and others in the household from the severe physical and emotional burdens of caregiving. The difficulties of caring for these veterans at home often become exacerbated during the course of illness, particularly if there is no break for the family. The patient may also benefit directly from respite care by virtue of treatment received in the institution. The critical element of respite arrangements is that the respite is planned in advance for the benefit of the caregiver, rather than being incidental to the provision of necessary medical care of the patient. VA currently lacks clear statutory authority to furnish respite care. While the use of respite care authority may help delay the need for prolonged institutionalization, we recommend that such a program be initiated on an evaluative, pilot basis, and that its scope be limited to those veterans having the highest claim to VA health care, service-connected veterans. Under our proposal, we would anticipate providing respite care at a

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limited number of facilities in conjunction with hospital based home care programs in one-week lengths of stay for up to four times a year. Care would be furnished in beds that would otherwise be unoccupied, and, since respite patients generally would receive nursing level care, these beds would be staffed accordingly. We would also limit the scale of the pilot program so that its cost would not be significant in magnitude. We believe that a three-year program would provide us with sufficient experience to determine the future of respite care by VA.

VA/COMMUNITY SHARING

Section 9 of the bill is intended to expand the scope of resources that may be shared with the community. Among the strengths of our health care system are the close relationships and cooperation between our facilities and the general medical community. An important element in these relationships is the program of sharing between VA medical centers and certain community health-care facilities. Since 1966, when Congress established this authority the scope of VA/community sharing has increased. In fiscal year 1985, 120 VA medical centers had some 284 agreements with community health care facilities to share some $38 million in services. We consider the program to be very successful.

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Although we continue to explore opportunities for further sharing with community facilities, expansion is limited by the scope of our current sharing authority. Most significantly, this authority limits VA medical centers to providing only specialized medical resources as defined by law. Limiting sharing to specialized medical resources has prevented us from sharing many resources that might benefit community institutions and also provide VA with full cost reimbursement.

Based on our experience with sharing health-care resources with DOD, we believe such legislation making sharing under section 5053 more flexible would permit our medical facilities to achieve greater efficiencies without adversely affecting the priority and availability of our services to veterans, and without additional costs to VA.

We believe the draft bill should be revised to limit the sharing of nonspecialized medical resources to cases where the VA would not be displacing third party private sector providers. The reason for this position is that we want to avoid pitting the resources of the federal government against small business concerns that make their living by providing services to hospitals. We also believe that the bill should be modified to clarify what resources VA may share and to address the scope of institutions which may share under section 5053.

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Current law limits sharing to VA hospitals and thus precludes VA outpatient clinics from initiating agreements. Likewise, current law does not authorize VA to enter into an agreement with a research center or nursing home, for example. We would recommend modifying current law to permit such arrangements. We also recommend that authority be given to authorize VA to enter into multi-year agreements, subject to the availability of funding. Currently, all sharing arrangements must undergo annual re-negotiation that can be disruptive to continuity of shared programs. This is particularly true at medical centers with substantial sharing arrangements.

We will be pleased to work with the committee staff in refining this proposal.

VA/DOD HEALTH RESOURCES SHARING

In 1982, with the enactment of Public Law 97-174, Congress mandated that VA and the Defense Department promote greater health-care resources sharing. Public Law 97-174 contained incentives for VA and DOD health-care facilities to negotiate sharing agreements. As a result, our health-care facilities have expanded such cooperative efforts every year since 1982. Currently, 101 VA health-care facilities have one or more agreements to share a broad spectrum of health-care resources with DOD facilities. Overall, last fiscal year, DOD purchased some $22 million in services from us, and we purchased some $8 million in services from them. We believe this law has been

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very successful in improving delivery of services to VA and DOD beneficiaries without increasing the overall costs to the Government.

Currently, only DOD medical facilities may enter into VA/DOD sharing agreements. We understand that the Department of Defense feels that it is important to maintain this requirement in order to insure that DOD medical administrators retain control over the entire range of care provided to their beneficiaries. Thus, DOD opposes that section of this bill which would authorize DOD military units to enter into sharing agreements with VA.

EXTEND PERIOD FOR SPECIAL PAY REPORT

We endorse the provision extending to four years the interval for the VA report to the President on the pay comparability of its physicians and dentists and recommending "appropriate" amounts of special pay. The current interval for this report is every two years.

The report is intended to ensure that the total pay of the VA physicians and dentists is reasonably comparable with pay for non-VA physicians and dentists so that VA can effectively continue to recruit and retain well-qualified physicians and

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dentists. Given the purposes of the report and its importance for VA operations, two years allows insufficient time to properly conduct the required study of pay patterns, prepare the report, and approve and implement any recommended changes to the special pay program. In effect, by the time a report is compiled, assembled, analyzed, and prepared, the next report must be initiated. An interval of four years between reports would allow time to implement and fully analyze changes so as to ensure that the next report reflects current comparisons based on modifications effected as a result of the preceding report.

NURSE SCHOLARSHIP PROGRAM CHANGES

The bill would also change the method for calculating the period of obligated service required of certain participants in the VA's Health Professional Scholarship Program. The change would only affect participants who attend school on a part-time basis. VA favors this change which is actually quite technical in nature.

The scholarship program pays for the education of both full-time and part-time students pursuing baccalaureate degrees in nursing. In return, these individuals agree to work for VA for a period of time. The obligation for a full-time student is two years. The obligation of a part-time student is reduced from

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that of a full-time student by the proportion the person attends school in relation to full-time attendance. Calculating the precise obligation is very complicated, posing a risk of errors. Perhaps more important is that, because the current method makes the precise obligation unknown until schooling is complete, part-time students find it very difficult to make plans for the future.

The proposal would provide that a part-time student must serve six months as a full-time employee for each calendar year or part of a calendar year in which the participant received scholarship support. The current minimum obligation of one year would remain unchanged. The change would make the service obligation more predictable, easier to administer, and more resistant to disputes.

VET CENTERS

Mr. Chairman, you have asked us to address in our testimony the proposed Readjustment Counseling Program Amendments of 1986. These amendments are apparently intended to maintain the provision of readjustment counseling services in Vet Centers, as well as to establish a counseling fellowship program modeled after VA's Nurse Scholarship Program.

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First, this legislation would delete the statutory requirement that VA, by October 1, 1988, complete a transition under which readjustment counseling services would be provided primarily in VA medical centers rather than in "Vet Centers." For a number of reasons, we recommend deferral of this proposal.

Existing law provides specifically that in the twelve month period preceding October 1, 1988, VA must provide for the orderly transition of the readjustment counseling program from one providing services in "storefront" vet centers to one providing services primarily in traditional VA medical centers. Six months prior to the beginning of the transition period, however, the Administrator must report to the Congress on the effectiveness of the readjustment counseling program, and the report would include recommendations regarding continuation of the vet centers. The report to the Congress must include opinions regarding the need for continued provision of readjustment counseling, the need for continued use of vet centers to meet such needs, and a recommendation for appropriate administrative or legislative action. Finally, the law directs that, in assessing the effectiveness of the program, (mandated by Public Law 98-160) the Administrator must give attention to the results of a study of post-traumatic stress disorder and other post-war psychological problems.

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There is certainly merit to having VA thoroughly evaluate the readjustment counseling program, as present law directs, and report to the Congress by April 1, 1987. Because the Administrator has just begun his tenure at the VA, he has not had the opportunity to conduct the evaluation of this program contemplated by the Congress.

Also, as you are aware, VA is now conducting the study mandated by Public Law 98-160 on post-traumatic stress disorder. That in-depth study is still underway, and has not yet produced preliminary findings which might help shape this policy judgment. We believe, as the present law contemplates, that a decision on the need for continuation of the vet center program should be deferred until those findings are received and can be included in an evaluation of the program.

Finally, Public Law 99-166, enacted last year, mandated creation of a pilot program to convert a number of vet centers into resource centers to provide Vietnam era veterans with a number of services in addition to readjustment counseling. That pilot program is just now getting underway. Deferring action on this proposal would better enable us to preliminarily evaluate the effectiveness of this pilot effort and its implications regarding the means by which the Agency can best deliver readjustment counseling and related services in the future.

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READJUSTMENT COUNSELING PROFESSIONAL FELLOWSHIP PROGRAM

Section 3 of the proposed bill would establish a Readjustment Counseling Fellowship Program to award scholarships to individuals to pursue graduate study in disciplines which would be appropriate to furnishing readjustment counseling services. Participants receiving a scholarship would be required to serve as a readjustment counselor with the VA for two years after completion of the course of training. The proposed fellowship program is patterned after, and would be administered in the same manner as, the VA's Health Professional Scholarship Program, which awards scholarships to nursing students who agree to work for the VA after completion of their education. Payments for tuition, education expenses, and a monthly stipend would be the same as those for the nurse scholarship program. To be eligible to receive a scholarship under the proposed fellowship program, however, an individual must be a veteran who served during the Vietnam era.

We do not currently have a problem in recruiting or retaining qualified professionals to serve as counselors in our Vet Centers. If a problem arises, it can be solved without resort to creation of a scholarship program. Alternative methods for improving recruitment and retention of needed counselors are available. Furthermore, we do not believe the proposed

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scholarship program is a particularly cost-effective method for obtaining qualified counselors. We would estimate that the average cost of the monthly stipend, tuition, and other expenses for a student pursuing graduate education would approach or exceed $10,000 per year.

PILOT PROGRAM - HOSPITAL MANAGEMENT

You also have before you, a bill to establish a hospital management pilot program. This measure is apparently intended to have VA operate five medical centers on an experimental basis through "waiver" of restrictive laws or regulations to achieve maximum efficiency.

We favor legislation that would provide VA authority to conduct a pilot program under which we could explore the feasibility of operating VA medical centers free of certain statutory constraints, which the Administrator determines are appropriate for waiver. We believe such an effort could lead to improvements to efficiency and effectiveness of our medical centers. In developing this pilot program, the VA will, of course, consult with veterans groups, congressional committees, federal agencies, and other concerned parties.

Finally, we note that the bill calls for annual reports on this initiative. It would be our intention to use the final report as a vehicle for evaluating this pilot project.

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AMEND PROCEDURES FOR DISCIPLINARY BOARDS

Finally, you asked that we testify on a proposal to limit the appointment of disciplinary boards for employees appointed under section 4104(1) of title 38. Under such a provision VA could simplify disciplinary procedures affecting these employees in cases where the proposed penalties are relatively light. VA supports the proposal, but would favor augmenting the bill to include authority for delegating both the power to appoint disciplinary boards and to act on disciplinary board recommendations.

Current law mandates a rather cumbersome peer review process for disciplinary actions against non-probationary physicians, dentists, podiatrists, optometrists, nurses, physician assistants and expanded-function dental auxiliaries, for reasons of inaptitude, inefficiency, or misconduct. There is no distinction between seriousness of offenses. Current procedures involve notice of charges, opportunity for a pre-decision hearing, right to legal representation and post-decision appeal. The hearing, required at the request of the employee, is a trial-type adversarial hearing of which a verbatim transcript is taken.

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AMFND PROCEDURES FOR DISCIPLINARY BOARDS

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The current disciplinary board system has proven to be overly centralized, time consuming and highly legalistic, with an average case taking between nine and fourteen months to complete. As the volume of disciplinary actions increases, further processing delays are incurred. The effect of the complexity of the current disciplinary board system has been to diminish the use and usefulness of disciplinary actions as a behavior-modifying measure to maintain high standards of patient care in the medical centers. The system discourages the proposal of moderate penalties and thus tends to frustrate the progressive discipline approach.

The current bill would limit the use of the disciplinary board machinery to cases where the proposed penalties are most serious: removal, suspension of more than 14 days, or demotions involving loss of grade or basic pay. All lesser disciplinary actions would be excluded. Administrative appeal or grievance procedures would be established for these latter actions under regulations prescribed by the Administrator pursuant to current authority. As a result, the volume of section 4110 disciplinary actions would be reduced. This would in turn reduce processing time for an average case. Further, lesser disciplinary actions would be more readily invoked so that progressive discipline would be more feasible.

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But we strongly believe any change to the disciplinary board process should clearly enable even those cases that remain covered by section 4110 to be more expeditiously resolved, by giving VA the power to delegate authority to appoint boards and act on board recommendations. The current bill, while providing for regulations to govern appointing boards, also repeals the current explicit authority to delegate both board appointments and review of board recommendations. Thus, the bill would require the involvement of the Administrator in the appointment and review process of each and every board case. Therefore it would not go far enough to solve the problems in the current system. VA favors changing the current system by expressly authorizing the Chief Medical Director to delegate his current board-appointing authority and by expressly empowering him to redelegate the authority currently delegated to him by the Administrator to act upon recommendations of the board. In addition, the current bill would appear to reach conduct only in connection with duty. It should be amended to authorize boards to hear issues involving off duty misconduct as well.

Decentralizing disciplinary board process would expedite board results and thus better serve the affected employee's interest in getting a timely result.

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We believe this provision would result in some limited cost savings through reduced expenses for processing disciplinary actions although the major benefits would be a more responsive and timely disciplinary system.

Mr. Chairman, my colleagues and I would be pleased to answer any questions you might have.

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Department of Medicine and Surgery Washington D.C. 20420

Veterans Administration

MAY 9 1986

In Reply Refer To: 10B/RC

Honorable Bob Edgar
Chairman, Subcommittee on
Hospitals and Health Care
Committee on Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am pleased to respond to your letter of April 23, 1986, concerning the "Study of Post-Traumatic Stress Disorder and Other Post-War Psychological Problems."

A White Paper on this study was promised during your Subcommittee's hearing on April 22, 1986. As you requested, the White Paper is enclosed. Copies have also been provided to Committee Chairman G.V. (Sonny) Montgomery and Ranking Minority Member John Paul Hammerschmidt.

Notwithstanding the delay in submitting the report on the study, the VA expects to submit its assessment of readjustment counseling services and recommendations for the future provision of such services by April 1, 1987 as required by P.L. 98-160. As discussed during the hearing other information is being collected about the services that Vietnam Veterans need and receive at Vet Centers, about the organization of our Vet Center Program, and the capability of Medical Centers to delivery those services. The information to be gained by the PTSD study will be beneficial to the agency in structuring its treatment programs for patients suffering from PTSD in any organizational or geographic setting that may be proposed in the April 1, 1987 Report to Congress.

I trust this information will be useful to the Committee.

Sincerely,

John W. Ditzler M.D.

JOHN W. DITZLER, M.D.
Chief Medical Director

Enclosure

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WHITE PAPER

READJUSTMENT COUNSELING SERVICE (10B/RC)

SUBJECT: Delay in Timetable of the National Vietnam Veterans Readjustment Study (NVVRS)

Background: Public Law 98-160 mandates that the VA shall carry out a nationwide study of post-traumatic stress disorder and other post-war psychological problems in Vietnam veterans. The law states that the results of this study will be reported to the Congress by October 1, 1986. The study is fully contracted out to the Research Triangle Institute (North Carolina). The contract award date was September 12, 1984.

The study is the largest, most comprehensive, and most systematic study of post-traumatic stress disorder and other readjustment problems of Vietnam veterans done to date. It is the first national-level epidemiologic study of any psychiatric disorder ever to be carried out in the United States. It is also the first epidemiologic study of major size to be done on post-traumatic stress disorder.

Relevant Aspects of Study Design: In order to fulfill the congressional mandate, a study has been designed which will make it possible to determine the presence or absence of post-traumatic stress disorder in a nationwide sample of approximately 2900 persons, with the resulting diagnosis to be validated by means of a follow-up survey using mental health professionals. In addition, it has been necessary to conduct a pilot test of the instrument package to be used in the national survey, to prove that the assessment of PTSD in the national survey is scientifically valid.

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Legislative Status and Timetable: Public Law 98-160 requires that the results of the study be submitted to Congress by October 1, 1986. The national study is eleven months behind timetable as of this date. The projected date for submission of the report on the study to Congress is now September 1, 1987.

Reasons for Delay: The reasons for the lengthened timetable for the study derive solely from the inherent scientific complexity and trail-blazing character of the study. Specifically, because the study is breaking new ground in the epidemiological assessment of post-traumatic stress disorder, it has been necessary to design and conduct a much more complex and thorough pilot test of the critical instrumentation, than was initially forecasted. This required significant time in the form of locating and identifying cases of post-traumatic stress disorder, who then had to be clinically diagnosed with unusually high validity, in order to obtain a standard against which to calibrate the instruments for the national survey.

In addition, the process of obtaining the various sub-samples required by law, has been an inherently more lengthy task than projected.

Contractor performance has not been a factor in producing the delay.

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Prospects for Timetable in the Future: The first interviews of the national sample are planned to begin August 15, 1986. In order to produce results desired by Congress in the shortest possible time, the basic study design calls for one-third of the national sample to be interviewed first, and then the data and conceptual analysis, plus the follow-up validity check on the PTSD diagnosis conducted on a sub-sample by mental health professionals, all to be carried out on a fast track. Interviews of the second and third sections of the national sample will begin while this fast-track analysis of the data from the first section is in progress.

This three-section or three-wave design was established at the inception of the study, in order to produce some results required by Congress as quickly as possible. The statistical validity of the results from the first wave, therefore, will be at an absolutely minimum level. While we feel confident that they will be confirmed and enriched by the results of the second and third waves, the basic structure of the study allows for no further compression of the timetable. The final and complete report on the study, including data on all three waves of the national samples, will be available, as presently projected, November 30, 1988, while the report on the first wave will be available, as indicated above, by September 1, 1987.

ARTHUR S. BLANK, JR., M.D.
Director, Readjustment Counseling (10B/RC)

April 24, 1986

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STATEMENT OF THE
HONORABLE G.V. (SONNY) MONTGOMERY
CHAIRMAN
VETERANS' AFFAIRS COMMITTEE
U.S. HOUSE OF REPRESENTATIVES
AT THE HEARING ON VARIOUS VA MEDICAL CARE
LEGISLATIVE PROPOSALS
APRIL 22, 1986

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I WANTED TO BE HERE WITH YOU THIS MORNING TO MAKE SOME OBSERVATIONS ABOUT THE BUDGET SITUATION AND THE RELATIONSHIP BETWEEN THE BUDGET AND THE LEGISLATION WE WILL CONSIDER.

WE HAVE BEEN VERY SUCCESSFUL IN THE PAST IN PROTECTING VETERANS BENEFITS FROM SIGNIFICANT BUDGET REDUCTIONS. HOWEVER, OUR ABILITY TO CONTINUE THESE SUCCESSES CERTAINLY IS BECOMING HARDER EVERY YEAR. YOU WILL RECALL WE HAD DIFFICULTY IN THE COMMITTEE LAST SESSION IN MEETING CUTS CONTAINED IN THE BUDGET RESOLUTION. WHAT WILL BE REQUIRED, IN THE FUTURE, I BELIEVE, ARE EXPLICIT ACTIONS TO SHOW OUR COLLEAGUES THAT WE CONSERVE VA'S RESOURCES.

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SUCH ACTIONS MUST INCLUDE THOROUGH REVIEWS OF THE PROGRAMS AND COST-EFFECTIVE USE OF FUNDS AND PERSONNEL. THESE ACTS ALONE WILL CONVINCE OUR COLLEAGUES THAT AUTHORIZING AND APPROPRIATING FUNDS FOR THE VA IS A SOUND PUBLIC POLICY DECISION. ONE EXAMPLE IS OUR RECENT IMPROVEMENT IN ELIGIBILITY FOR VA HEALTH CARE BENEFITS.

I'M HERE TO PRESENT TO THE SUBCOMMITTEE MY PERSONAL VIEWS ON H.R. 4623, REGARDING READJUSTMENT COUNSELING. ONE PROVISION IN THE BILL WOULD ELIMINATE THE REQUIREMENT THAT VET CENTERS BEGIN DELIVERING SERVICES PRIMARILY THROUGH VA MEDICAL CENTERS BY OCTOBER 1, 1988.

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AS YOU KNOW, VET CENTERS NOW PROVIDE SERVICES PRIMARILY IN FACILITIES SITUATED APART FROM VA MEDICAL CENTERS. THE OTHER PROVISION WOULD ESTABLISH AN ACADEMIC FELLOWSHIP PROGRAM FOR VIETNAM-ERA VETERANS TO LEARN READJUSTMENT COUNSELING SKILLS. IN EXCHANGE FOR FELLOWSHIP SUPPORT, SERVICE AS A READJUSTMENT COUNSELOR IN THE VA WOULD BE REQUIRED.

I WANT YOU TO KNOW THAT I CANNOT SUPPORT EITHER OF THESE TWO PROVISIONS AT THIS TIME.

AS I READ THE BILL, THIS PROVISION WOULD MAKE PERMANENT THE VET CENTER PROGRAM IN ITS CURRENT CONFIGURATION. I CAN'T SAY THAT THE BILL IS INTENDED TO DO THAT; HOWEVER, THAT IS HOW THIS LEGISLATION WILL BE PERCEIVED SHOULD IT BE ADOPTED.

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IF I AM WRONG IN MY READING OF THE BILL, THEN THERE IS NO REASON TO ACT ON THIS PROVISION NOW. EIGHTEEN MONTHS REMAIN BEFORE ANY ACTION ON THE PROGRAM IS REQUIRED BY LAW. INDEED, WE SHOULD EXERCISE RESPONSIBILITY AND WAIT UNTIL WE HAVE RECEIVED THE VA'S REPORTS ON THEIR RECOMMENDATIONS CONCERNING THE VET CENTER PROGRAM AND ITS FUTURE WHICH WE REQUIRED THE AGENCY TO DO. WE PASSED LEGISLATION THAT MANDATED TWO REPORTS IN PUBLIC LAW 98-160, DUE IN APRIL AND JULY OF 1987. THESE REPORTS CONCERN THE EFFECTIVENESS OF THE VET CENTER PROGRAM AND PLANS FOR THE FUTURE OF THE PROGRAM. IN ADDITION, THE CONGRESS HAS ALSO MANDATED A STUDY OF POST-WAR PSYCHOLOGICAL PROBLEMS WHICH IS DUE ON OCTOBER 1 OF THIS YEAR.

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IT IS NOT WISE AS A MATTER OF POLICY TO ANTICIPATE THE RESULTS OF THESE REPORTS. I FURTHER THINK THAT IT IS NOT WISE AS A MATTER OF CONSERVING THE VA'S MEDICAL CARE BUDGET TO ACT WITHOUT BENEFIT OF SOUND INFORMATION. IN OTHER WORDS, IT IS PREMATURE TO ACT NOW.

WITH REGARD TO THE PROPOSAL TO ESTABLISH A FELLOWSHIP PROGRAM FOR COUNSELORS, IT IS UNWISE TO DIVERT SCARCE MEDICAL CARE FUNDS TO A NEW PROGRAM, PARTICULARLY WHEN THERE HAS BEEN NO EVIDENCE PRESENTED TO THE COMMITTEE THAT THE VA IS HAVING DIFFICULTY RECRUITING QUALIFIED VET CENTER STAFF. REMEMBER, THE VA HAS REPORTED TURNING AWAY OVER 35,000 NON-SERVICE-CONNECTED VETERANS WHO APPLY FOR OUTPATIENT AND LONG-TERM HEALTH CARE EACH MONTH! WHERE IS THE MONEY FOR ANOTHER NEW PROGRAM?

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AS YOU MAY ALSO RECALL, THE ADMINISTRATION DID NOT REQUEST ANY FUNDS FOR THE NURSE SCHOLARSHIP PROGRAM FOR FISCAL YEAR 1987, NOTWITHSTANDING THE NURSE RECRUITING PROBLEMS THAT EXIST IN SOME FACILITIES. I CANNOT ENDORSE AUTHORIZING THIS NEW FELLOWSHIP PROGRAM WHEN WE CANNOT ADEQUATELY FUND THE EXISTING NURSES PROGRAM.

CERTAINLY I UNDERSTAND THE POLITICAL APPEAL OF THIS BILL. AS CHAIRMAN OF THE COMMITTEE I ALSO UNDERSTAND HOW DIFFICULT IT IS FOR US TO MAKE CUTS IN EXISTING PROGRAMS WHEN WE WERE REQUIRED TO DO SO IN RECONCILIATION BILLS IN YEARS PAST. REMEMBER THE SPLIT IN THE COMMITTEE LAST SESSION WHEN WE WERE MANDATED TO SAVE ABOUT $1 BILLION OVER THREE YEARS.

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TWELVE MEMBERS VOTED NO ON THE MEASURE MR. HAMMERSCHMIDT AND I PROPOSED TO THE COMMITTEE.

LET US NOT MAKE OUR WORK TOUGHER BY ACTING TO FIX A RECRUITING PROBLEM WHICH HAS NOT BEEN SHOWN TO EXIST OR BY PREJUDGING THE CONTENTS OF REPORTS WE HAVE ASKED FOR CONCERNING THE OUTREACH PROGRAM. IF WE SEE THAT SOMETHING NEEDS TO BE DONE, WE CAN DO IT NEXT YEAR. THERE IS NO REASON TO MOVE THIS BILL NOW. LET'S REMEMBER WE HAVE NOT PASSED A BUDGET RESOLUTION FOR FISCAL YEAR 1987 AND WE MAY BE MANDATED TO CUT BACK ON EXISTING PROGRAMS AGAIN FOR THE 1987 RECONCILIATION PROCESS.

SHOULD H. R. 4623 BE SCHEDULED FOR MARKUP, I PLAN TO OPPOSE IT. THANK YOU.

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Veterans Administration

Memorandum

Date: February 7, 1986

To: Associate Deputy CMD (10X1A)
Director for Operations (10B)
Report of the Vet Center Planning Committee

From: Chief Medical Director (10)

Subj:

The Vet Center Planning Committee has submitted a report with three recomendations for the future organization and role of the Readjustment Counseling program. Following is a discussion of the results of their work and our recommendations for your approval.

1. ISSUE 1. - Future organizational configuration. The Committee considered five options for the future organizational configuration of the program and recommended that:

- o The present Vet Center system be continued after FY88 with no alterations to its administrative organizational structure.
- o Reduction in program size, proceed if and as needed and utilization of services diminish.
- o The contracts portion of program to be downsized and resources redirected, if necessary, to Vet Centers.
- o Legislation be sought to allow DM&S to continue providing readjustment counseling services beyond FY88 in a manner determined by the agency.
- o Some center personnel be folded into VAMCs.

Discussion: We feel that this recommendation will permit DM&S to manage the program and not be driven by legislated madantes. The Readjustment Counseling program would retain its status as a special program, very closely cooperating with, but not immediately assimilated into the medical centers

10X/10B Recommendation: To accept the committee's organizational recommendaton.

APPROVE _____ DISAPPROVE _____

2/21/86

JOHN W. BITZLER, M.D.
Chief Medical Director

2. ISSUE 2 - Pilot Programs

The Committee felt that because the Vet Center model has high potential for delivering other DM&S services in addition to

VA FORM 2105
MAY 1983

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2.

SUBJ: Report of the Vet Center Planning Committee

readjustment counseling, Vet Centers should be tested as a possible way to provide efficient, community-based care. Therefore they recommended that HSR&D should establish a pilot program with individual VAMCs submitting proposals to be conducted within available medical center/vet center resources.

Discussion: This issue should be developed further, including an estimate of what research resources would be needed.

RECOMMENDATION: To defer the concept of a pilot program for further development and costing.

Approve_____Disapprove _____ Support encouraged if VVRC Pilot Prgm.

JOHN W. DITZLER, M.D.
Chief Medical Director

3. ISSUE 3. Expansion of Eligibility.

The Committee recommended tht DM&S staff should determine whether there is a need for readjustment counseling among combat veterans of other wars and the resource impact of such an expansion of eligibility.

Discussion: This would be an appropriate issue for the PSG/ PAB.

DECISION: To refer the issue of expansion of eligibility for readjustment counseling services to the PSG.

Approval_____Disapproval_____ Comments: Develop data for MAC review & PAB

8/4/86

JOHN W. DITZLER, M.D.
Chief Medical Director

B. Earl Brown Jr.
Associate Deputy CMD (10)

K. E. Lindsay
Director for Operations (10B)

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NATIONAL ASSOCIATION OF STATE VETERANS HOMES

OFFICE OF Chairperson, Legislative Committee

May 3, 1985

Honorable G.V. (Sonny) Montgomery, Chairman
Committee on Veterans' Affairs
House of Representatives
Room 335
Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

The National Association of State Veterans Homes appreciated the opportunity to have its Legislative Committee present testimony to the Sub-Committee on Hospitals and Health Care on May 2, 1985, on the matter of HR-505, the Veterans Health Care Omnibus Bill. Our testimony dealt specifically with that part of the Bill relating to revision of the State Home Construction Grant Program.

Our Legislative Committee was privy, on very short notice, only to the discussion draft of the proposed amendments to the State Home construction funding mechanism. The discussion draft contained several provisions which we felt were detrimental to the total effort of Congress and the states to achieve greater state participation in veteran health care and our comments reflected this concern.

The National Association of State Veterans Homes Legislative Committee attended the markup session for the bills and thus became aware of the Committee's more recent version of State Home Construction Grant Amendments which the Sub-Committee adopted for reporting to the Full Committee on Veterans' Affairs. We have carefully reviewed the adopted amendments and are pleased to inform you that they are fully supported by the National Association of State Veterans Homes.

One major concern expressed by the Sub-Committee was that the current "first-come, first-served" grant award system operates to discourage those states newly interested in the Program from making application for federal funds. This discouragement was seen as a byproduct of the long waiting list for those funds which now exists due to the fact that states already providing State Home services have initiated action to get into the queue for funding. States not currently operating homes have not had the benefit of knowledge of the Program or how to use it.

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Congressman Edgar questioned us as to whether we could support a division of the Construction Grant Appropriation into separate pockets for (1) funding of new Homes in new states, and (2) funding the correction, renovation and expansion of Homes already existing. We concurred in this approach but note that the concept did not appear in the language adopted by the Sub-Committee and forwarded to the Full Committee.

In an effort to assist with a resolution to the priority problem, we would respectfully offer an implementory suggestion. Perhaps it would be appropriate for the Committee Report directing Veterans Administration implementation of HR-505 to require that the Administrator's report submitted under Title 38, 5033a, 2A and B (i)(ii), contain two lists of recommendations; one being for new Homes in states not currently providing State Home services, the second being for states desiring to improve or expand their facilities. In this manner, we believe, a more equitable method for attracting new states into this cost-effective Program could be developed without penalizing existing State Homes. This could prove beneficial to both State and Federal Agencies, particularly if the appropriated program funding matches the authorized amounts contained in HR-505.

Mr. Chairman, let me again assure you that the National Association of State Veterans Homes fully supports your Committee's effort to enhance expansion of the State-Federal partnership which is so well developed in the operation of State Veterans Homes. We are pleased to support HR-505 and hope that our suggestion is worthy of further consideration.

Sincerely,

Jack J. Dack

Jack J. Dack
Chairperson, Legislative Committee
National Association of State
Veterans Homes
Commandant, Iowa Veterans Home
Marshalltown, IA 50158

JJD:rah

cc: See attached list

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cc: Honorable Robert W. Edgar
Congress of the United States
U.S. House of Representatives
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NATIONAL ASSOCIATION OF STATE VETERANS HOMES

TESTIMONY

April 22, 1986

To The
Subcommittee Hospitals and Health Care
on Veterans' Affairs

UNITED STATES HOUSE OF REPRESENTATIVES

Support for Legislation to Extend the Authority for the Program of Construction Grants to States for State Home Facilities: "Older Veterans Health Amendments and the Extension of the Authority of Certain Medical Programs".

Submitted by:
Jack J. Dack, Chairman
National Association of
State Veterans Homes
Legislative Committee
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158

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NATIONAL ASSOCIATION OF STATE VETERANS HOMES

Mr. Chairman and Members of the Committee:

The National Association of State Veterans Homes appreciates the opportunity to express its views pertinent to the "Older Veterans Health Amendments and the Extension of the Authority of Certain Medical Programs".

We feel our involvement to be extremely important with the increasing demands being made upon our federal government for funding in taking care of our veterans, particularly those increasing numbers of elderly veterans who are reaching that time in life when the long-term health care delivery system will be stretched beyond capacity to partially meet this demand.

The State Veterans Home Program has grown from eleven homes in eleven states in 1888 to presently 53 homes in 35 states. Nursing home care is provided in 42 homes, domiciliary care in 46 homes, and hospital care in 7 homes. These homes presently have over 18,000 beds and, in FY 85, provided more than 4.6 million days of care (domiciliary 1,588,787; nursing home 2,863,430; hospital 182,076).

The program of assistance to states for construction, remodeling, and renovation of State Home facilities began on August 19, 1964, with the enactment of Public Law 88-450, which authorized annual appropriations of $5 million for making grants to State Homes by the Veterans Administration. These grants were limited to no more than 50% of the cost of constructing new nursing care facilities, expanding or remodeling buildings for use as nursing care facilities, and initially equipping such facilities. Not more than 10% of the funds appropriated for any fiscal year could be used to assist in construction of nursing home care facilities in any one state.

Since inception of the Construction Grant Program over 21 years ago, Public Laws 90-432, 93-82, and 97-251 have extended the program through 1986. Interspersed legislation, however, has significantly changed the program.

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A. 1969 P.L. 91-178: Expanded grants to states for assistance in remodeling, modification, or alteration of existing hospital or domiciliary facilities in State Homes providing care and treatment to veterans.

B. 1973, P.L. 93-82: Changed the Veterans Administration participation rate from 50% to 65% and limited beds to two and one half per thousand veteran population of a state.

C. 1979, P.L. 85-62: Redefined construction to mean new domiciliary or nursing home buildings and expansion, remodeling, and alteration of existing buildings for the provision of domiciliary, nursing home care, or hospital care in State Homes and the provision of initial equipment for any such buildings. This Public Law changed the veteran occupancy requirement in State Homes receiving a construction grant from 90% to 75%. This act also changed the amount that any one state may receive in any fiscal year to one third of the amount appropriated in such fiscal year.

D. 1979, P.L. 96-151: Continued authorization of $15 million through 1980 and provided for such sums as were necessary for 1981 and 1982.

E. 1980, P.L. 96-330: Removed the legal limitation of two and a half beds per thousand veteran population in a state and left to the Administrator to prescribe the number of beds required to provide adequate nursing home care to veterans residing in each state. Regulations have established a ceiling of four beds per thousand veterans, with justification required if construction would result in nursing home beds in excess of two and a half beds per thousand veterans in each state.

F. 1984, P.L. 98-528: Expanded grants to states for acquisition of existing facilities to be used as State Homes as long as the cost plus renovation does not exceed the cost of the new construction.

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G. 1985, P.L. 99-166: Deleted the deadline for availability of state construction funds and deferral of certain applications.

Since 1975, we have noted increased amounts of funding available, except for Fiscal Year 1980.

Fiscal Year	Amount (thousands)
1975	9,700
1976	10,000
1977	10,000
1978	15,000
1979	10,000
1980	7,500
1981	15,000
1982	15,840
1983	18,000
1984	18,000
1985	34,500
1986	20,822 (after 4.3% Gramm-Rudman reduction)

It was in Fiscal Year 1975, following the increase in the percentage participation by the federal government in 1973, that interest by the states in the program seemed to grow. There is a backlog of applications at the federal level awaiting consideration for funding. (Exhibit A) As of February 28, 1986, eligible preapplications and applications involving 70 projects with an estimated grant request of $175,195,000 have been submitted.

Presently, there are 35 states with 50 veterans homes and three annexes. It is noted that twelve (12) states with veterans homes are establishing additional homes, which will provide an increase of 2,490 nursing and 350 domiciliary beds. Six (6) states with homes are increasing nursing care beds for an additional total of 527. Six (6) states have demonstrated interest in establishing veterans homes through discussion, preapplication, or application (Mississippi, Tennessee, Virginia, Alabama, Florida, and Kentucky). Nine (9) states at this time appear to have little/no interest in establishing a veterans home (Alaska, Arizona, Delaware, Hawaii, Nevada, North Carolina, Oregon, Texas, and Utah).

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In general, the greatest interest in increased participation is in those states with existing homes where the state commitment to care for veterans has been accepted. In states without a veterans home, it may be five to fifteen years from the time a state first demonstrates interest until funding is provided for construction of a home.

A historic review of the program reveals that of the $189.9 million obligated from Fiscal Year 1966 through December 31, 1985, 136 projects out of an approved 179 have been completed. Expenditures of funds have resulted in 7,543 beds either through new construction or remodeling (50 projects--6,332 nursing care; 11 projects--1,211 domiciliary). One hundred eighteen (118) projects involve or have been involved with renovation for life safety, privacy, or to meet regulatory programmatic changes. The overall federal matching funds participation is 59.5% out of a maximum 65%. (Exhibits B and C)

The passage of legislation to extend the program, which the National Association of State Veterans Homes totally supports, is vital to the combined state and federal efforts focused on meeting the increasing needs of the nation's aging veteran population. While the total veteran population will get smaller from the present 27.8 million to 24.3 million in the year 2000, it will get older. The group of veterans at least 65 years of age, which now numbers close to 5 million, will grow to about 9 million. Veterans 65 and over will account for about 18% of the total veteran population. This proportion will rise steadily over the next three decades before peaking at 45% by the year 2015.

The Administration proposed shift to a 30% state-supported census will require additional State Veterans Home beds. These beds probably cannot be attained without continued support for increased appropriations for Grants for Construction of State Extended Care Facilities. In view of the current backlog depicted in Exhibit A and the lengthy time period for obtaining federal assistance, states are reluctant to establish or expand the program.

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We in the Association are pleased with the recommended $42.4 million request in the Veterans Administration Fiscal Year 1987 Medical Care Budget for Grants for Construction of State Extended Care Facilities. This funding will assist in reducing the backlog of pending construction applications.

Increased funding for state construction projects will be a step in the right direction. However, again, with the recent shift in provider mix (state 20-30%, federal 40-30%, and community 40%), it is important that the per diem rates which are prescribed by law reflect the same consideration. Both sections of the program, construction and per diem, must walk hand in glove for the capacities to exist in the states to absorb the additional work load which will result both from the shifting of service from the Veterans Administration and from the aging of the veteran population in the states themselves. Appropriate levels of funding in both programs must be maintained to encourage those states currently providing veterans home services to retain and expand these services as well as to encourage additional states not currently providing state veterans homes to get into the program.

States expending efforts to assist in this problem, however, are becoming concerned over the increasing financial burden of such programs. The State Veterans Home Program has been determined to be a cost-effective alternative to providing long-term health care services in Veterans Administration facilities. Several state facilities are dealing with money freezes, budget cuts, and similar reduction measures reflecting fiscal problems being encountered by these states. It is noted that the operating expenditure of the State Veterans Home programs for Fiscal Year 1985 was an increase of approximately 6.5% over 1984. According to the Consumer Price Index, January, 1986, the national inflation rate in health care services was hovering around 6.9%, with an appearance, over time, of an upward spiral. Despite the past generosity of Congress, the per diem rates paid states continue to lag behind the accepted 30% federal proportionate share of funding. (Exhibit D)

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Veterans Administration Federal Grants Applicable to Domiciliary, Nursing, and Hospital Care Provided by State Veterans Homes

Cost Shared by Veterans Administration and Veterans Homes

FY 1984

	Veterans Days of Care	Average Daily Census	Average Per Diem Cost	Total Veteran Cost	Grant in Aid by VA	Percent By VA
Domiciliary	1,613,173	4,407.2	$ 37.61	$ 61,215,115	$10,999,292	17.9%
Nursing	2,752,816	7,491.1	$ 60.84	$173,539,868	$39,215,861	22.5%
Hospital	188,190	514.4	$198.16	$ 26,196,068	$ 2,704,923	10.3%
	Overall Average		$ 57.30		Overall Percent	20.28%

FY 1985

Domiciliary	1,588,787	4,360	$ 37.62	$ 60,754,667	$11,618,718	19.12%
Nursing	2,863,430	7,863	$ 65.39	$129,530,055	$48,759,404	25.33%
Hospital	182,076	499	$210.15	$ 29,307,597	$ 2,776,659	9.4%
	Overall Average		$ 60.42		Overall Percent	22.35%

We in the Association are most concerned about maintaining the per diem rates at the 30% level for two reasons:

1. The care furnished by state veterans facilities is typically for severely disabled or impaired veterans who demonstrate a need to receive nursing care over a protracted period of time. This places the State Homes in the unique position of caring for severely debilitated patients requiring extensive amounts of care over a long-term period. This has become increasingly noticeable with the advent of the Diagnosis Related Groups (DRG) concept to providing care in community acute care facilities. This concept has been implemented in the Veterans Administration Medical Centers.

2. We feel continuation of the current per diem rates will be viewed as a further disincentive to both the full operation of existing State Home facilities and possible creation of additional beds to meet the demand of the aging World War II veteran.

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Public Law 98-160 mandates that every three years the Veterans Administration shall submit a report to the Committees on Veteran Affairs of the Senate and House of Representatives on the adequacy of the per diem rates. The first report is to be submitted June 30, 1986. This report is to be based on the projections over each of the following five years of the demand on the Veterans Administration for the provision of nursing care to eligible veterans. With nursing home care services provided in state veterans homes being increased to 30%, apparently the demand for care has been determined by the administration. We would ask the Committees' continued support to maintain per diem rates at the 30% level.

We note with envy that the nursing care costs of the Veterans Administration and the community contract nursing home rates are adjusted annually as a part of the budget process. The per diem rates for the State Veterans Home Program are not, thus the need for us to come to the Congress to seek support for our request for rate enhancement.

Patient Obligation Data*

Activity	1985 Actual	1986 Budget	1986 Estimate	1987 Estimate	Increase (+) Decrease (-)
Av. Obligation/Patient/Day:					
Medical Bed Section	$308.75	$308.06	$324.54	$335.24	+$10.70
Intermediate Bed Section	$135.32	$139.08	$141.02	$145.09	+$ 4.07
VA Nursing Homes	$111.94	$114 02	$113.84	$120.04	+$ 6.20
VA Domiciliaries	$ 43.62	$ 45.45	$ 41.70	$ 46.11	+$ 1.41
Community Nursing Homes	$ 59.87	$ 66.69	$ 64.38	$ 69.53	+$ 5.15
State Home Domiciliaries	$ 7 30	$ 7.30	$ 7.30	$ 7.30	---
State Home Nursing	$ 17.05	$ 17.05	$ 17.05	$ 17.05	---
State Home Hospital	$ 15.25	$ 15.25	$ 15.25	$ 15.25	---

*Medical Programs, Fiscal Year 1987, Volume II, Office of Budget and Finance (Controller), February, 1986, Washington, D.C.

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The National Association of State Veterans Homes has developed and submitted to both the Senate and House Veteran Affairs Committees a proposal and rationale for an increase in per diem payments for State Veterans Homes maintaining the tradition that Congress has held that the rates should be at the 30% level. (Exhibit E) Again we would ask your support of this request.

With the shift in the provider mix of health care services for Veterans Administration sponsored programs in long-term care for veterans, the federal government is turning more to the states to provide for those who have served. What better way to provide the quality of care they deserve than being cared for in a State Veterans Home? The services provided by the State Veterans Homes reflect a sensitivity and an acknowledgement of the contribution made by its patients. In addition, it is cost-effective and high quality.

Mr. Chairman, we in the National Association of State Veterans Homes understand that there is a legislative proposal by the Veterans Administration to discontinue the Office for Geriatrics and Extended Care as presently established. We understand there would be a complete shift of the long-term care programs to an Office of Clinical Affairs which is currently acute care oriented. The members of the National Association of State Veterans Homes is opposed to such a move. The present Office of Assistant Chief Medical Director for Geriatrics and Extended Care in which the State Veterans Home Program is located serves the 53 homes and 35 states very well. It can be viewed as a "one-stop shopping center". We work closely with Dr. John H. Mather, Mr. Brent Baker, and Ms. Marsha Goodwin of that office in regards to the overall State Veterans Home programming. We are not lost in a maze or referred to and from and back again to receive a response to a concern or question regarding the State Home Program. In most cases, a prompt response is received. The staff is most professional, dedicated, concerned, and helpful. It, indeed, would be a tremendous loss to have the State Home Program integrated and buried within an acute care area

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of responsibility. The Association feels the interest generated in long-term care programming would be lost to acute care concerns and initiatives. In addition, we feel the close working relationship now existing between the participating states, interested states, and the Veterans Administration could be destroyed.

This close working relationship between the National Association of State Veterans Homes and the Veterans Administration was formalized on February 24, 1986, with the signing of a "Memorandum of Understanding". (Exhibit F) This was to formalize the long-standing efforts of the National Association of State Veterans Homes and the Veterans Administration through the Office for Geriatrics and Extended Care to provide quality care to veterans. Both organizations agreed to work together to identify areas for enhancing the quality of care for veterans through an exchange of information. Areas of focus include the establishment, expansion, and renovation of State Veterans Homes and the results of research by the Veterans Administration, State Homes, the National Association of State Veterans Homes, and the agencies or individuals pertinent to long-term care and the elderly.

Representatives from the Veterans Administration and the National Association of State Veterans Homes will meet on a regular basis to develop strategies and target dates for implementing goals regarding long-term care programming.

Credit must be given to Dr. Mather, Assistant Chief Medical Director for Geriatrics and Extended Care, and his State Home Program staff for their dedication to task, cooperativeness, and continuing interest in the State Veterans Home Program. We in the Association would not want to lose this federal and state impetus in the area of long-term health care planning.

While the Congress of the United States has been most generous in providing for its veterans, and the Veterans Administration has done an outstanding job within the

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so are becoming limited. We must work closer together, share ideas, stretch and share resources, and assist one another if we are going to fulfill our mutual obligation.

The nation's commitment to take care of its veterans must be met. There is nothing illogical in sharing this burden with the states.

Thank you.

Jack J. Dack, Chairman
National Association of
State Veterans Homes
Legislative Committee
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158

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EXHIBIT A

Eligible Preapplications and Applications for
Grants for Construction of State Extended Care Facilities
(pending approval - dollars in thousands)

2/28/86

FAI No.	State (locality)	Project	Estimated Grant Request
24-003	MD (Charlotte Hall)	(3rd Phase - 126 Dom/NH Beds)	3,047
24-004	MD (Charlotte Hall)	(4th Phase - 126 Dom/NH Beds)	5,298
17-007	IL (Quincy)	Renovation Andrew	351
17-008	IL (Quincy)	Energy Conservation	117
06-014	CA (Yountville)	Rem. Sec. D Dom-Life Safety	2,117
34-010	NJ (Paramus Phase II A)	New State Home - 240 Bed NH	11,644
28-001	MS (Jackson)	New State Home - 150 Bed NH	4,388
30-002	MT (Columbia Falls)	50 Bed NH Wing	1,203
25-029	MA (Chelsea)	Elevators	78
25-030	MA (Chelsea)	Renovations	76
06-012	CA (Yountville)	Remodel Hospital Ward 1A	118
37-N003	PA (Hollidaysburg)	Renovations-NHC-Grant Increase	99
37-N004	PA (Hollidaysburg)	Renovations-Dom-Grant Increase	191
13-004	GA (Milledgeville)	150 Bed NH	4,550
27-006	MN (Hastings)	Grant Increase	474
17-010	IL (Quincy)	Life Safety - Fire Alarm	144
42-009	PA (Hollidaysburg)	Renovate Dietary Building	1,800
06-013	CA (Yountville)	Rem. Sec. B to Dom Life Safety	2,179
06-011	CA (Yountville)	Cooling Plant and Piping	1,359
06-015	CA (Yountville)	Rem. Sec. E Life Safety	1,729
06-016	CA (Yountville)	Rem. Hospital Support Service	1,300
06-017	CA (Yountville)	Rem. Nursing Home 1-3 AB	1,557
06-018	CA (Yountville)	Rem. Sec. F - Handicapped	1,299
06-019	CA (Yountville)	Rem. Workshop - Sprinkler	98
36-002	NY (Long Island)	New 350 Bed NH	14,780
06-020	CA (Yountville)	Rem. Sec. H Dom-Fire & Safety	1,105
06-021	CA (Yountville)	Rem. Sec. J Dom-Fire & Safety	1,105
06-022	CA (Yountville)	Rem. Sec. K Dom-Fire & Safety	1,105
06-023	CA (Yountville)	Rem. Sec. L Dom-Fire & Safety	1,105
06-024	CA (Yountville)	Rem. NHC Wings 1-3C-D	1,557
05-002	AR (Little Rock)	Conversion 70 Dom Beds to NH	195
42-008	PA (Hollidaysburg)	Renovation-Sommer-225 NH Beds	4,091
44-003	RI (Bristol)	Domiciliary Renovation	1,138
12-001	FL (Lake City)	New State Home 150 Bed Dom	2,730
39-002	OH (Sandusky)	Grant Increase NHC	221
29-004	MO (St. James)	Replace NHC Unit (+50 Beds)	2,420
40-009	OK (Clinton)	Replace NHC Unit	965
16-002	ID (Boise)	Renovate Dom/NHC Beds	1,105
39-009	OH (Sandusky)	Power Plant	1,409
06-025	CA (Yountville)	Remodel NHC Wards 2-3 E	813
06-026	CA (Yountville)	Remodel Annex I NHC	1,170
06-027	CA (Yountville)	Remodel Annex II NHC	1,170
06-034	CA (Yountville)	Remodel Ground & 1st Fl. Hosp.	650
06-028	CA (Yountville)	Remodel Dom Sec. G & LSC	1,463
54-003	WV (Pruntytown Phs. I)	Remodel School for 202 NHC	2,961
54-004	WV (Pruntytown Phs. II)	Remodel School for 94 Bed Dom	2,602

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EXHIBIT A

FAI No.	State (locality)	Project	Estimated Grant Request
06-031	CA (Yountville)	Renovate Kitchen & Dining Room	195
06-032	CA (Yountville)	Renovate Hospital Food Service	195
06-029	CA (Yountville)	Renovations - Storage Areas	195
06-033	CA (Yountville)	Renovations - Sprinkler System	98
06-035	CA (Yountville)	Renovations - Admin. Building	98
39-003	OH (Sandusky)	New 300 Bed Dom Replacement	9,223
39-010	OH (Sandusky)	New 200 Bed Dom Replacement	5,188
01-001	AL (Alexander City)	New 150 Bed NHC	4,615
29-005	MO (SE)	New 150 Bed NHC	5,850
29-006	MO (NW)	New 150 Bed NHC	5,850
39-011	OH (Sandusky)	Add 100 NHC Beds, Secrest	2,918
40-010	OK (Claremore)	New 250 Bed NHC	8,450
42-010	PA (Pennhurst Phase I)	Renov. for 180 NHC; 150 Dom	4,011
42-011	PA (Pennhurst Phase II)	Construct 270 NHC Beds	7,670
45-002	SC (Anderson)	New 220 Bed NHC	5,850
55-011	WI (King)	Renovate NHC Unit	3,187
16-003	ID (Eastern ID)	New 72 Dom/60 NHC	2,979
19-026	IA (Clarinda)	Remodel for 68 NHC	2,118
19-027	IA (Marshalltown)	Dietary Facility	1,841
23-002	ME (Biddeford)	New 120 NHC	4,875
26-004	MI (Macomb)	New 170 NHC/84 Dom	3,307
40-011	OK (Talihina)	NHC Addition +51 Beds	1,999
40-012	OK (Clinton)	Dining/Kitchen Facility	1,034
42-012	PA (Pennhurst)	Dietary Facility	2,373
			175,195

Summary (as of February 28, 1986)	
Funds Available from FY 86	20,822
Funds Available from FY 85	15,537
Funds Available from FY 84	3,047
	39,406
Projects eligible for which funds are not available	135,789

Remarks:

1. 34-010 NH (Paramus) Phase II & III combined as Phase II Amended with estimate from $10,185 to $11,644.

2. 24-003 MD (Charlotte Hall) deobligated '84 funds for Phase III: $3,047,179.

Office of Extended Care (182C)
Department of Medicine & Surgery
Veterans Administration
Washington, D.C.

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STATUS OF GRANTS FOR CONSTRUCTION OF STATE HOMES

COB 12/31/85

EXHIBIT B

Appropriation 36-/-0181.40	Appropriated Amount	Apportionment	Unappor-tioned	Obligated	Unobligated Balance
FY 1966 - 1983	151,040,000	151,040,000	0	148,990,027	2,049,973
FY 1984(Exp.9/30/86)	18,000,000	18,000,000	0	18,000,000	0
FY 1985(Exp.9/30/87)	34,500,000	34,500,000	0	18,962,783	15,537,217
FY 1986(Exp.9/30/88)	21,758,000	21,758,000	0	0	21,758,000
GRAND TOTAL	225,298,000	225,298,000	0	185,952,810	39,345,190

Project Number	Location	Number of Beds	Total Est. Cost	Oblig. Chngs During Month	VA Funds Obligated
05-001	AR,LITTLE ROCK	150 D	1,912,416		1,243,071 *
04-N001	CA,YOUNTVILLE		66,803		43,422 *
04-N002	CA,YOUNTVILLE		288,529		187,544 *
04-N003	CA,YOUNTVILLE		101,362		65,885 *
04-N004	CA,YOUNTVILLE		435,512		283,083 *
04-N005	CA,YOUNTVILLE		829,924		529,268 *
04-N006	CA,YOUNTVILLE		63,900		41,535 *
04-N007	CA,YOUNTVILLE		133,806		86,974 *
06-008	CA,YOUNTVILLE		11,428,657		7,428,627
06-009	CA,YOUNTVILLE		4,237,750		2,754,537
06-010	CA,YOUNTVILLE		3,156,450		2,051,692
05-N004	CO,FLORENCE	120 N	1,331,310		848,164 *
05-N001	CO,HOMELAKE		30,727		19,399 *
05-N002	CO,HOMELAKE		122,908		79,890 *
05-N003	CO,HOMELAKE		200,000		127,981 *
05-N005	CO,HOMELAKE		133,557		86,794 *
08-006	CO,HOMELAKE		436,467		283,687 *
08-007	CO,RIFLE	100 N	3,571,428	2,321,428	2,321,428
06-N001	CT,ROCKY HILL		171,675		107,859 *
06-N002	CT,ROCKY HILL		131,159		85,253 *
09-N003	CT,ROCKY HILL		181,408		109,398 *
09-004	CT,ROCKY HILL		1,038,581		533,827 *
09-005	CT,ROCKY HILL		247,875		150,339
09-006	CT,ROCKY HILL		275,500		168,756
09-007	CT,ROCKY HILL		341,395		181,431
09-008	CT,ROCKY HILL		508,181		330,317
10-N001	GA,AUGUSTA	192 N	1,956,000		977,857 *
10-N002	GA,MILLEDGEVILLE	132 N	1,718,599		859,299 *
10-N003	GA,MILLEDGEVILLE		4,130,231		1,766,409 *
14-N001	IA,MARSHALLTOWN	80 N	1,063,826		527,822 *
14-N002	IA,MARSHALLTOWN		205,324		102,305 *
14-N003	IA,MARSHALLTOWN		73,278		36,638 *
14-N004	IA,MARSHALLTOWN		10,842		5,421 *
14-N005	IA,MARSHALLTOWN		40,450		17,253 *
14-N006	IA,MARSHALLTOWN		4,822		2,233 *
14-N007	IA,MARSHALLTOWN		2,266		1,079 *
14-N008	IA,MARSHALLTOWN		9,644		4,509 *
14-N009	IA,MARSHALLTOWN		1,560		1,094 *
14-N010	IA,MARSHALLTOWN		14,820		7,401 *

*Completed Projects

D = DOM
N = Nursing Home

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EXHIBIT B

Project Number	Location	Number of Beds	Total Est. Cost	Oblig.Chngs During Month	VA Funds Obligated	
14-N016	IA,MARSHALLTOWN		3,960		1,745	*
14-N017	IA,MARSHALLTOWN		10,194		4,356	*
14-N020	IA,MARSHALLTOWN	360 N	12,622,882		7,875,314	*
14-N021	IA,MARSHALLTOWN		148,922		94,110	*
14-N022	IA,MARSHALLTOWN		1,845,985		1,259,758	*
14-N023	IA,MARSHALLTOWN	180 N	7,767,876		4,947,331	*
19-024	IA,MARSHALLTOWN		2,194,000		1,568,000	*
19-025	IA,MARSHALLTOWN		589,948		383,467	
16-001	ID,BOISE	90 (80N,10D)	2,222,807		1,367,851	*
17-005	IL,MANTENO	300 N	18,093,876		11,761,020	
12-N001	IL,QUINCY	200 N	2,882,000		1,374,731	*
17-002/3	IL,QUINCY		518,518		409,872	*
17-004	IL,QUINCY		222,840		144,846	
17-009	IL,QUINCY		500,000		325,000	
13-N001	IN,LAFAYETTE	100 N	5,640,262		2,799,138	*
13-N002	IN,LAFAYETTE	150 N	6,891,985		3,326,531	*
15-N001	KS,FT.DODGE	88 N	830,000		414,563	*
22-001	LA,JACKSON	235 (35N,200D)	8,675,000		5,000,000	*
20-N002	MA,CHELSEA		44,000		22,000	*
20-N003	MA,CHELSEA		7,500		3,750	*
20-N004	MA,CHELSEA		19,500		9,750	*
20-N005	MA,CHELSEA		21,000		10,500	*
20-N006	MA,CHELSEA		10,830		5,415	*
20-N007	MA,CHELSEA		6,750		3,375	*
20-N008	MA,CHELSEA		2,858,962		1,564,038	*
20-N019	MA,CHELSEA		581,000		366,114	*
20-N020	MA,CHELSEA		1,111,770		505,434	*
20-N021	MA,CHELSEA		138,037		70,205	*
20-N022	MA,CHELSEA		54,594		28,820	*
20-N023	MA,CHELSEA		12,000		7,872	*
20-N025	MA,CHELSEA		75,808		46,161	*
25-027	MA,CHELSEA		127,857		80,430	*
25-028	MA,CHELSEA		90,300		38,020	*
20-N001	MA,HOLYOKE	155 N	1,898,000		735,716	*
20-N010	MA,HOLYOKE		513,390		304,397	*1/
20-N011	MA,HOLYOKE		342,260		222,469	
20-N012	MA,HOLYOKE		7,770		5,050	
20-N013	MA,HOLYOKE		3,330		2,165	
20-N014	MA,HOLYOKE		11,100		7,215	
20-N015	MA,HOLYOKE		33,300		21,645	
20-N016	MA,HOLYOKE		18,870		12,265	
20-N017	MA,HOLYOKE		11,988		7,792	
20-N018	MA,HOLYOKE		8,722		5,670	
23- 001	ME,AUGUSTA	120 N	4,472,000		2,906,800	
24- 001	MD,CHARLOTTE HALL	126 D	9,455,000		5,909,687	
24- 002	MD,CHARLOTTE HALL	126 D	5,225,897		3,266,186	
24- 003	MD,CHARLOTTE HALL	126 D	4,375,486		3,047,179	
21-N001	MI,GRAND RAPIDS	537 N	7,688,568		3,702,005	*
26-002	MI,GRAND RAPIDS		14,065,100		9,142,315	
26-003	MI,MARQUETTE		4,289,291		2,788,039	
27- 006	MN,HASTINGS		1,968,700		1,279,330	
22-N001	MN,MINNEAPOLIS	250 N	9,035,365		5,867,715	
22-N002	MN,MINNEAPOLIS		76,799		49,919	*
22-N003	MN,MINNEAPOLIS		51,188		33,272	*
22-N004	MN,MINNEAPOLIS		250,000		162,282	*
22-N005	MN,MINNEAPOLIS		100,000		65,218	*

*Completed Projects

D = DOM
N = Nursing Home

1/Holyoke Total 10/18 = $617,975

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EXHIBIT B

Project Number	Location	Number of Beds	Total Est. Cost	Oblig. Changes During Month	VA Funds Obligated	
24-N001	MO,ST. JAMES	60 N	966,100		483,019	*
29- 002	MO,ST. JAMES		603,122		365,370	
29- 003	MO,MEXICO	150 N	6,335,791		4,104,959	
25-N001	MT,COLUMBIA FALLS	40 N	448,685		219,783	*
26-N001	NB,GRAND ISLAND	100 N	2,043,737		743,723	*
26-N002	NB,GRAND ISLAND	100 N	1,141,415		533,470	*
26-N003	NB,GRAND ISLAND		114,306		55,385	*
26-N004	NB,SCOTTS BLUFF		617,855		401,606	*
31- 005	NB,SCOTTS BLUFF	50 N	2,075,630		1,349,160	
33-N001	ND,LISBON		54,235		35,117	*
33-N002	ND,LISBON		1,727,161		1,122,655	
28-N001	NH,TILTON	50 N	748,000		373,583	*
28-N002	NH,TILTON	50 N	1,768,054		1,111,363	*
29-N002	NJ,MENLO PARK	100 N	1,925,000		943,374	*
29-N004	NJ,MENLO PARK	100 N	1,766,873		867,211	*
29-N007	NJ,MENLO PARK		347,147		138,866	*
34-008	NJ,MENLO PARK		1,148,165		746,307	*
34-009	NJ,PARAMUS	114N	9,715,358		5,926,368	
29-N001	NJ,VINELAND	100 N	1,296,801		559,808	*
29-N003	NJ,VINELAND	100 N	2,846,241		967,064	*
29-N005	NJ,VINELAND	100 N	3,544,819		1,463,987	*
34-N006	NJ,VINELAND		433,293		288,140	*
35-002	NM,TRUTH/CONSEQ		5,400,000		3,475,980	
34-N001	OH,SANDUSKY	300 N	9,795,489		6,179,386	*
39-002	OH,SANDUSKY		7,879,500		5,109,856	
35-N005	OK,ARDMORE		47,912		31,143	*
40-008	OK,ARDMORE	100 N	2,247,083		1,460,604	*
35-N002	OK,CLINTON		135,000		66,528	*
35-N004	OK,CLINTON	36 N	499,943		324,962	*
35-N007	OK,CLINTON		122,760		79,794	*
35-N001	OK,NORMAN	50 N	459,514		229,757	*
35-N003	OK,NORMAN		32,682		15,806	*
35-N006	OK,SULFUR		106,877		69,470	*
37-N001	PA,ERIE		739,126		264,210	*
37-N002	PA,ERIE	75 N	2,322,091		1,458,317	*
37-N005	PA,ERIE		175,000		138,294	*
42-007	PA,ERIE		1,776,846		487,692	
37-N003	PA,HOLLIDAYSBURG	200 N	3,147,988		2,212,721	
37-N004	PA,HOLLIDAYSBURG	212 D	2,890,258		1,582,666	
42-006	PA,HOLLIDAYSBURG		951,130		618,235	
38-N001	RI,BRISTOL	165 N	705,838		352,919	*
38-N002	RI,BRISTOL	150 N	3,905,342		2,538,472	*
39-N001	SC,COLUMBIA	115 N	1,982,000		687,174	*
40-N001	SD,HOT SPRINGS		42,186		27,364	*
46-008	SD,HOT SPRINGS		29,872		19,370	*
44-N001	VT,BENNINGTON	22 N	251,939		122,461	*
44-N002	VT,BENNINGTON	40 N	1,284,680		437,301	*
44-N003	VT,BENNINGTON		61,650		30,825	*
44-N004	VT,BENNINGTON	73 N	3,650,422		2,075,836	*
44-N005	VT,BENNINGTON		341,139		221,740	*
50-006	VT,BENNINGTON	50 N	6,146,600		3,995,290	

*Completed Projects

D = DOM
N = Nursing Home

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EXHIBIT B

Project Number	Location	Number of Beds	Total Est. Cost	Oblig. Changes During Month	VA Funds Obligated	
46-N001	WA,ORTING		25,319		7,373	*
46-N002	WA,ORTING		50,784		11,377	*
46-N003	WA,ORTING		256,776		166,905	*
46-N004	WA,ORTING		161,619		105,052	*
46-N005	WA,ORTING		66,359		43,133	*
46-N006	WA,ORTING		30,968		20,129	*
46-N007	WA,ORTING		243,692		158,400	*
46-N008	WA,ORTING		365,540		237,602	*
46-N015	WA,ORTING	40 N	1,793,823		1,143,138	*
46-N016	WA,ORTING		631,780		410,657	*
46-NG17	WA,ORTING		755,793		500,851	*
46-N009	WA,RETSIL		220,011		143,007	*
46-N010	WA,RETSIL		330,017		214,511	*
46-N011	WA,RETSIL	78 N	2,633,863		1,692,784	*
46-N012	WA,RETSIL		1,144,749		744,087	*
46-N013	WA,RETSIL		272,681		177,243	*
46-N014	WA,RETSIL		409,022		265,864	*
46-N018	WA,RETSIL		135,342		87,972	*
46-N019	WA,RETSIL		90,288		57,311	*
48-N001	WI,KING	200 N	2,867,697		1,164,131	*
48-N002	WI,KING	200 N	3,223,000		1,479,202	*
48-N003	WI,KING		95,130		47,565	*
48-N004	WI,KING		44,768		22,084	*
48-N005	WI,KING		105,428		45,410	*
48-N006	WI,KING		150,000		73,240	*
48-N007	WI,KING		311,330		200,846	*
48-N008	WI,KING		350,160		226,089	*
48-N009	WI,KING		116,721		75,869	*
55-010	WI,KING	45 N	7,720,000		5,018,000	
13-N001	WY,BUFFALO		386,000		250,900	*
56-002	WY,BUFFALO	60 D	2,805,000		1,716,000	*
54-001	WV,BARBOURSVILLE	47 D	2,141,538		1,392,000	
54-002	WV,BARBOURSVILLE	154 D	1,917,998		1,116,258	
GRAND TOTALS		7543	312,493,880	2,321,428	185,952,810	

*Completed Projects

D = DOM
N = Nursing Home

Office of Extended Care (182C)
Department of Medicine & Surgery
Veterans Administration
Washington, D.C.

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EXHIBIT C

STATUS OF GRANTS FOR CONSTRUCTION OF STATE HOMES
SUMMARY

STATE	NUMBER OF BEDS DORM	NURSING	TOTAL ESTIMATED COST	V.A. FUNDS OBLIGATED	NUMBER OF PROJECTS	NUMBER OF PROJECTS COMPLETED
AR	150		1,912,416	1,243,071	1	1
CA			20,742,693	13,472,567	10	7
CO		220	5,826,397	3,767,343	7	6
CT			2,895,774	1,667,180	8	4
GA		324	7,804,830	3,603,565	3	3
IA		620	26,610,599	16,839,836	18	17
ID	10	80	2,222,807	1,367,851	1	1
IL		500	22,217,234	14,015,469	5	2
IN		250	12,532,247	6,125,669	2	2
KS		88	630,000	414,563	1	1
LA	200	35	8,675,000	5,000,000	1	1
MA		155	8,008,638	4,086,268	25	17
ME		120	4,472,000	2,906,800	1	0
MD	378		19,556,383	12,223,052	3	0
MI		537	26,042,959	15,632,359	3	1
MN		250	11,482,052	7,457,736	5	4
MO		210	7,905,013	4,953,348	3	1
MT		40	448,685	219,783	1	1
NB		250	5,992,943	3,083,344	5	4
ND			1,781,396	1,157,772	2	1
NH		100	2,516,054	1,484,946	2	2
NJ		614	23,033,697	11,901,125	9	8
NM			5,400,000	3,475,980	1	0
OH		300	17,674,989	11,289,242	2	1
OK		186	3,651,771	2,278,064	8	8
PA	212	275	12,002,439	6,762,135	7	3
RI		315	4,611,180	2,891,391	2	2
SC		115	1,982,000	687,174	1	1
SD			72,058	46,734	2	2
VT		185	11,736,430	6,883,453	6	5
WA		118	9,618,426	6,187,396	19	19
WI		445	14,984,234	8,352,436	10	9
WY	60		3,191,000	1,966,900	2	2
WV	201		4,059,536	2,508,258	2	0
TOTAL	1,211	6,332	312,493,880	185,952,810	179	136
	7543					

Appropriation 36-/-0181.40	Appropriated Amount	Apportionment	Unappor-tioned	Obligated	Unobligated Balance
FY 1966 - 1983	151,040,000	151,040,000	0	148,990,027	2,049,973
FY 1984 (Exp. 9/30/86)	18,000,000	18,000,000	0	18,000,000	0
FY 1985 (Exp. 9/30/87)	34,500,000	34,500,000	0	18,962,783	15,537,217
FY 1986 (Exp. 9/30/88)	21,758,000	21,758,000	0	0	21,758,000
GRAND TOTAL	225,298,000	225,298,000	0	185,952,810	39,345,190

bg/02-03-86

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EXHIBIT D

VA FEDERAL GRANTS APPLICABLE TO DOMICILIARY, NURSING, AND HOSPITAL CARE PROVIDED BY STATE HOMES

FY 1985

DOMICILIARY CARE 39 WITH 3 ANNEXES

COST SHARED BY VETERANS ADMINISTRATION & VETERANS HOME

		VETERAN DAYS OF CARE	AVERAGE DAILY CENSUS	AVERAGE PER DIEM COST	TOTAL VETERAN COST	GRANT-IN-AID BY VA	PERCENT OF COST
Summary		1,588,787	4,360	$37.62	$60,754,667.60	$11,618,778.00	19.12%
AR	Little Rock	35,130	96.1	27.91	980,473.00	256,084.00	26.12%
CA	Yountville	231,255	633.5	50.28	11,627,501.40	1,688,161.50	14.52%
CO	Homelake	26,952	73.8	23.92	644,691.80	197,012.40	30.56%
CT	Rocky Hill	125,784	344.7	24.00	3,018,816.00	918,223.20	30.42%
GA	Milledgeville	64,741	177.4	60.11	3,891,581.50	472,609.30	12.14%
ID	Boise	32,877	89.3	25.21	828,829.20	239,982.10	28.95%
IL	Quincy	35,550	97.4	42.54	1,512,297.00	259,515.00	17.16%
IN	Lafayette	34,896	95.3	45.57	1,590,210.70	254,740.80	16.02%
IA	Marshalltown	36,216	92.2	36.95	1,338,181.20	264,376.80	19.76%
KS	Fort Dodge	24,556	67.3	27.91	685,357.90	179,258.80	26.16%
LA	Jackson	25,857	70.8	43.14	1,115,470.90	188,756.10	16.92%
MD	Charlotte Hall*	4,540	27.5	25.30	114,862.00	33,142.00	28.85%
MA	Chelsea	97,743	267.8	21.92	2,142,526.50	713,523.90	33.30%
MA	Holyoke	12,948	35.5	24.39	315,801.70	94,520.40	29.93%
MI	Grand Rapids	53,559	146.9	27.01	1,446,628.60	390,980.70	27.03%
MI	Marquette	26,230	71.9	61.41	1,610,784.30	191,479.00	11.89%
MN	Hastings	64,754	177.4	29.45	1,907,005.30	472,704.20	24.79%
MN	Minneapolis	66,227	181.4	24.92	1,650,376.80	483,457.10	29.29%
MO	St. James	12,262	33.6	27.69	339,534.80	89,512.60	26.36%
MT	Columbia Falls	21,583	59.0	28.25	609,719.80	157,555.90	25.84%
NB	Grand Island**	45,798	125.5	37.15	1,701,395.70	334,325.40	19.65%
NJ	Menlo Park	13,662	37.4	40.78	557,136.40	99,732.00	17.90%
NY	Oxford	21,806	59.7	97.67	2,129,792.00	159,183.80	7.47%
ND	Lisbon	37,826	104.0	24.48	925,980.50	276,129.80	29.82%
OH	Sandusky	94,935	260.0	36.36	3,451,836.60	693,026.00	20.08%
OK	Ardmore	24,561	67.6	44.72	1,098,367.90	179,295.30	16.32%
OK	Clinton	10,570	28.9	48.61	513,807.70	77,161.00	15.02%
OK	Normon***	0	0.0	0.00	0.00	0.00	0.00%
OK	Sulphur	5,655	15.5	45.42	256,850.10	41,281.50	16.07%
PA	Erie	25,641	70.2	48.17	1,235,126.90	187,179.30	15.15%
PA	Hollidaysburg	61,943	169.7	58.79	3,641,628.90	452,183.90	12.42%
RI	Bristol	16,792	46.0	53.04	890,647.70	143,336.80	16.09%
SD	Hot Springs	26,686	73.1	23.89	637,528.50	194,807.80	30.56%
VT	Bennington	5,203	14.3	26.49	137,827.50	37,981.90	27.56%
WA	Orting	21,793	59.7	48.57	1,058,486.00	159,088.90	15.03%
WA	Retsil	51,466	141.0	39.13	2,013,864.60	375,701.80	18.66%
WV	Barboursville	56,330	154.3	29.04	1,635,823.20	411,209.00	25.14%
WI	King	16,722	45.6	42.83	716,203.30	122,070.60	17.04%
WY	Buffalo	17,738	48.6	44.07	781,713.70	129,487.40	16.56%

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EXHIBIT D

VA FEDERAL GRANTS APPLICABLE TO DOMICILIARY, NURSING, AND HOSPITAL CARE PROVIDED BY STATE HOMES

NURSING CARE TOTAL — 41 WITH 2 ANNEXES — FY 1985

	COST SHARED BY VETERANS ADMINISTRATION & VETERANS HOME					
Summary	VETERAN DAYS OF CARE	AVERAGE DAILY CENSUS	AVERAGE PER DIEM COST	TOTAL VETERAN COST	GRANT-IN-AID BY VA	PERCENT OF COST
	2,863,430	7,883	$65.39	$192,530,055.40	$48,759,404.50	25.33%
CA Yountville	234,040	641.2	90.80	21,250,832.00	3,990,382.00	18.78%
CO Florence	35,203	96.5	49.31	1,735,859.90	600,211.20	34.58%
CO Homelake	7,836	21.5	46.58	365,000.90	133,603.80	36.60%
GA Augusta	63,220	173.2	61.46	3,885,501.20	1,077,901.00	27.74%
GA Milledgeville	77,322	211.8	110.04	8,508,512.80	1,318,140.10	15.49%
ID Boise	28,662	77.9	58.30	1,670,994.60	488,687.10	29.11%
IL Quincy	142,879	392.2	59.37	8,482,726.20	2,436,086.90	28.72%
IN Lafayette	89,975	245.8	54.11	4,869,547.30	1,534,073.70	31.51%
IA Marshalltown	185,021	506.9	75.49	13,967,235.30	3,154,608.10	22.59%
KS Fort Dodge	19,099	52.3	42.48	811,325.20	325,637.90	40.14%
LA Jackson	40,140	110.0	38.44	1,542,981.60	684,387.00	44.35%
ME Augusta	37,216	102.2	67.05	2,495,332.80	634,532.70	25.43%
MA Chelsea	18,796	51.7	39.94	753,907.40	321,835.80	42.69%
MA Holyoke	91,290	250.1	68.99	6,298,097.10	1,556,491.50	24.71%
MI Marquette	198,519	544.0	65.37	12,977,187.00	3,384,748.90	26.08%
MN Minneapolis	22,228	60.0	71.66	1,592,858.50	378,987.40	23.79%
MO Mexico*	108,016	296.0	52.05	5,622,232.80	1,841,672.80	32.76%
MO Mount Vernon	1,773	56.3	82.37	310,782.00	64,329.70	20.70%
MO St. James	34,788	95.3	43.35	1,508,059.80	593,135.40	39.33%
MT Columbia Falls	58,883	161.3	43.10	2,537,857.30	1,003,955.20	39.56%
NB Grand Island**	22,330	61.2	58.42	1,304,518.60	380,726.50	29.19%
NH Tilton	180,074	493.3	55.42	9,979,701.80	3,070,261.70	30.77%
NJ Menlo Park	32,116	88.0	57.75	1,758,431.30	547,577.80	31.14%
NJ Vineland	115,742	317.1	97.78	6,687,572.80	1,973,401.10	29.51%
NY Oxford	93,683	256.6	75.54	7,076,813.80	1,597,295.20	22.57%
OH Sandusky	23,574	64.6	108.70	2,562,493.80	401,936.70	15.69%
OK Ardmore	98,891	265.4	55.13	5,451,860.80	1,651,992.00	30.30%
OK Clinton	37,338	102.2	66.84	2,495,671.90	636,612.90	25.51%
OK Mormon	46,376	127.0	74.35	3,448,055.50	790,710.80	22.93%
OK Sulphur	63,190	173.3	68.67	4,339,257.30	1,077,389.50	24.83%
OK Talihina	47,846	131.2	79.25	3,791,795.50	815,774.30	21.51%
PA Erie	57,058	156.3	70.88	4,044,271.00	972,838.90	24.05%
PA Hollidaysburg	24,982	68.5	112.02	2,798,483.60	425,943.10	15.22%
RI Bristol	70,396	192.8	92.52	6,513,037.90	1,200,250.80	18.43%
SC Columbia	97,576	267.3	67.03	6,540,519.30	1,663,670.80	25.44%
SD Hot Springs	53,296	146.0	40.77	2,172,877.20	908,697.80	41.82%
VT Bennington	10,785	29.5	51.38	554,133.30	154,545.80	27.89%
WA Orting	43,434	118.9	64.15	2,786,291.10	740,549.70	26.58%
WA Retsil	37,626	103.1	66.64	2,507,396.60	641,523.30	25.59%
WI King	48,175	131.9	67.87	3,269,501.50	821,349.70	25.12%
	162,038	442.8	69.45	11,253,539.10	2,762,747.90	24.55%

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EXHIBIT D

VA FEDERAL GRANTS APPLICABLE TO DOMICILIARY, NURSING, AND
HOSPITAL CARE PROVIDED BY STATE HOMES

FY 1985

HOSPITAL CARE TOTAL 7

	COST SHARED BY VETERANS ADMINISTRATION & VETERANS HOME					
	VETERAN DAYS OF CARE	AVERAGE DAILY CENSUS	AVERAGE PER DIEM COST	TOTAL VETERAN COST	GRANT-IN-AID BY VA	PERCENT OF COST
Summary	182,076	499	$210.15	$29,307,597.90	$2,776,659.40	9.47%
CA Yountville	9,575	26.2	445.93	4,269,775.70	146,018.70	3.42%
CT Rocky Hill	110,580	302.8	121.72	13,459,797.60	1,686,345.00	12.53%
IL Quincy	5,781	15.9	199.87	1,155,448.50	88,160.60	7.63%
IA Marshalltown	6,788	18.6	171.30	1,162,784.40	103,517.70	8.90%
MA Chelsea	44,241	121.2	183.21	8,105,393.60	674,675.30	8.32%
MA Holyoke	4,714	12.9	235.31	1,109,251.30	71,888.50	6.48%
OK Sulphur	397	1.1	113.72	45,146.80	6,054.30	13.41%

KEY:
* = New State Homes recognized during the fiscal year.

** = State Home with Annexes.

*** = State Home Nursing Home that retains 4 Domiciliary Beds.

Column 3 - Average Per Diem Cost - The State Home per diem cost is based on the cost of operation divided by the total days of patient (veteran/non-veteran) care during the fiscal year. The average per diem cost is the total veteran cost divided by the total veteran days of care.

Column 5 - Grant-In-Aid by VA - The per diem rates for FY 1985 were $7.30 for domiciliary care, $17.05 for nursing home care, and $15.25 for hospital care.

NOTE: Cost figures are unaudited.

Office of Extended Care (182C)
Department of Medicine & Surgery
Veterans Administration
Washington D. C.

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FEBRUARY 4, 1986 EXHIBIT E

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

SUPPORT RATIONALE FOR A PROPOSAL BY THE NATIONAL ASSOCIATION OF STATE VETERANS HOMES FOR AN INCREASE IN PER DIEM PAYMENTS FROM THE VETERANS ADMINISTRATION.

The National Association of State Veterans Homes respectfully requests that the per diem rates paid by the Veterans Administration to the states for the care of eligible veterans within State Veterans Homes be established in the 1987 Veterans Administration budget at $23.60 per day for nursing home care, $14.10 per day for domiciliary care and $76.25 per day for hospital care. In reviewing the federal-state partnership which exists througn the Veterans Administration-State Home Program, the Congress has traditionally held that the Veterans Administration rate should be 30 percent of the average daily rate of all homes participating in the State Home Program. Public Law No. 98-160 established that the adequacy of the rates paid to the state homes would be reviewed by the Veterans Administration every third year. The first such report is to be submitted not later than June 30, 1986.

With this in mind, the National Association in developing this request, took the period 1987 through 1989 and established the rate at the estimated mid-point of the triennial review period. The law already provides that in no case shall the payments made with respect to any veteran exceed one-half of the cost of the veteran's care in a State Home.

Published comments on the draft of the Executive Order 1987 Budget indicate that the proposal calls for a "new long-term care policy," emphasizing the use of community nursing homes and state institutions rather than additional federal facilities. The State Home Program has for years proven itself a high quality, cost-effective alternative to the direct provision of care in federal facilities, a fact which the Executive Budget seems to recognize. However,

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EXHIBIT E

this recognition comes at a time when several state home facilities are dealing with hiring freezes, budget cuts and similar restrictive measures reflecting fiscal problems being encountered by many states. Continuation of the current per diem rate will be seen as a further disincentive to both the full operation of existing state home facilities and the creation of the needed additional beds to accommodate the large and rapidly aging population of World War II veterans now coming into our facilities in significant numbers.

The National Association of State Veterans Homes notes, according to the Consumer Price Index, December 1985, a national inflation rate in health care services hovering around 6.8 percent with a longitudinal appearance of an upward spiral. The experience of the state home facilities further demonstrates their cost-effectiveness in that state homes are experiencing a 6.42 percent annual inflation rate. This inflation rate is built into the base calculations for the rates being requested.

The attached table illustrates the calculation base used by the National Association of State Veterans Homes in determining the requested rates. We observe that all rates are currently well below the 30 percent target share and further note that the soon-to-be-finalized Veterans Administration Regulations changing the focus of domiciliary care to a rehabilitative mode carry a strong potential for adverse impact on the cost of operations of state home domiciliaries.

It is important to note the role which the state home program plays in the overall scope of long-term care provided to veterans. The Veterans Administration nursing home units are increasingly focusing their efforts on the short-term

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EXHIBIT E

rehabilitation of hospitalized veterans. Care in community contract homes is normally limited to a period of six months with some options for renewal. The care furnished by the state veterans facilities is typically for severely disabled or impaired veterans who demonstrate a need for receiving nursing care over a protracted period of time, thus placing the state homes in the unique position of caring for severely debilitated patients requiring extensive amounts of care over a long-term period.

This has become increasingly noticeable with the advent of the Diagnosis Related Groups (DRG) concept of providing care in community acute care facilities and presently being implemented in the Veterans Administration Medical Centers. Without an adequate federal reimbursement structure for the states sponsoring state veterans homes, the expansion and/or full utilization of present capacity required for this long-term nursing care will not exist at that precise time in history when it is most critically needed.

It is thus that the National Association of State Veterans Homes urges your serious consideration and your subsequent approval of this request for improved per diem payments from the Veterans Administration to states for health care services provided veterans within state veterans facilities.

Jack J. Mack, Commandant
Iowa Veterans Home
Marshalltown, Iowa
Legislative Chairperson
National Association of
State Veterans Homes

JJD:rah

Attachment

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NATIONAL ASSOCIATION OF STATE VETERANS HOMES

COMPARISON OF VETERANS ADMINISTRATION AND STATE HOME ACTUAL COSTS, PER DIEM PAYMENTS AND ESTIMATED COSTS

FOR THE YEARS ENDING SEPTEMBER 30, 1984 THROUGH 1992

	1984		1985		1986		1987	1988	1989		
	Actual Aver. VA Payments or Costs	Actual Aver. State Home Costs	Actual Aver. VA Payments or Costs	Actual Aver. State Home Costs	Estimated Aver. VA Payments or Costs	Estimated Aver. State Home Costs (1)	Estimated Aver. State Home Costs (1)	Estimated Aver. State Home Costs (1)	Estimated Aver. State Home Costs (1)	30% of 87-89 Avg.(2)	Per Diem Rates To Be Requests (2)
NURSING HOME CARE:											
Veterans Administration	$ 107.84*		$ 111.94		$ 113.84		$ 120.04				
Community Contract	$ 55.19*		$ 59.87		$ 64.39		$ 69.53				
State Home Program	$ 14.60	$ 60.84	$ 17.05	$ 65.39	$ 17.05	$ 69.24	$ 73.74	$ 78.53	$ 83.63	$ 23.59	$ 23.60
Percentage of VA Payment to State Home Costs		24.00%		26.07%		24.62%					
DOMICILIARY CARE:											
Veterans Administration	$ 41.65*		$ 43.62		$ 46.70		$ 45.11				
State Home Program	$ 7.10	$ 37.61	$ 7.30	$ 37.62	$ 7.30	$ 41.42	$ 44.11	$ 46.98	$ 50.03	$ 14.11	$ 14.10
Percentage of VA Payment to State Home Costs		18.88%		19.40%		17.62%					
HOSPITAL CARE:											
Veterans Administration Intermediate Care Beds	$ 122.37**		$ 135.22		$ 141.02		$ 145.09				
State Home Program	$ 13.84	$ 198.16	$ 15.25	$ 210.15	$ 15.25	$ 223.81	$ 238.36	$ 253.85	$ 270.35	$ 76.26	$ 76.25
Percentage of VA Payment to State Home Costs		6.98%		7.26%		6.81%					

NOTES: (1) The State Home Program estimated costs are based on an annual inflation rate of 6.5% and was arrived at using the current cost data.

(2) Historically the per diem rate paid by the V.A. has been based on 30% of the average daily rate of all homes participating in the State Home Program.

* Summary of medical programs September, 1985, VA Office of Information, Management and Statistics.

** Medical programs Fiscal Year 1986 Volume II Office of Budget and Finance (Controller), Washington, D.C.

EXHIBIT E

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EXHIBIT F

Memorandum of Understanding
between the
Veterans Administration
and
National Association of State Veterans Homes

The Veterans Administration (VA) and the National Association of State Veterans Homes (NASVH) agree to work together, as set forth in this memorandum of understanding, for the purpose of achieving their mutual goal of providing quality care for veterans.

There has been a longstanding relationship between the VA and the State Veterans Homes. The Federal government began per diem payments to state homes in 1888 for veterans receiving domiciliary care. The Federal assistance to state homes was expanded in 1939 to include hospital care. In 1964, P.L. 88-450 further expanded the Per Diem Grant Program to include veterans receiving care in State Home Nursing Homes and initiated the State Home Construction Grant Program. State Home Per Diem Grants and State Home Construction Grants are approved and administered by the Veterans Administration within defined legislative authority. Each State that chooses to participate in either or both of the State Home Grants Programs initiates and controls the overall establishment, management, and operation of a state home within defined Federal, State, and local regulations. Therefore, the State Home Program is a Federal-State cost sharing program with each entity having specific responsibilities.

The National Association of State Veterans Homes (NASVH) was established in 1952 as an integrated entity for the purposes of 1) promoting legislation on the national level, and 2) sharing problems and experiences common to all State Homes. The most recent goals adopted by the NASVH are:

1. to provide appropriate quality care services to eligible disabled and elderly veterans and their dependents in State Veterans Homes;

2. to provide a clearinghouse for techniques and expertise in the care of veterans and the management of our institutions (State Homes);

3. to insure solidarity in the presentation of State Home requirements to Congress and the VA and of their responsibility of meeting these needs;

4. to encourage continued financial participation of the Federal government in the construction of state home facilities and the care of veterans in state homes; and

5. to encourage and assist other states to establish new state homes.

The VA and the NASVH have the mutual goal of providing quality care to veterans. Therefore, both organizations agree to work together to identify areas for enhancing the quality of care for veterans through exchanging facts and information concerning the care of veterans.

Goals: The following are the initial goals to be achieved:

1. to exchange information on efforts to encourage and assist states to establish new state homes, and expand/renovate existing state homes and state home programs.

2. to exchange information on VA and state home resources that could be shared under current legislative authority governing the VA and each state home.

3. to establish a formal means of exchanging information on the results of research and experience related to planning for and provision of long term care of veterans conducted by the VA, state homes, NASVH, and/or other agencies or individuals involved in long term care.

Implementation Plan:

The VA and the NASVH representatives would meet on a quarterly basis to develop strategies and target dates for implementing the goals. Subject areas may include:

- **Information Sharing and Dissemination**

1. current methods of encouraging and assisting states to establish new state homes;

2. types of medical information which the respective organizations might exchange in such areas as geriatrics and gerontology, medical research, long term care service delivery, and cooperative health care education services.

3. listings of VA and State Home officials responsible for planning, maintaining and evaluating quality health services for veterans in need of long term care.

4. current representatives of the VA and State Homes in planning, maintaining and evaluating quality health services for veterans in need of long term care.

- **Review and Implementation Procedures**

1. identify plans for fully implementing the joint goals.

2. determine resources available and needed for implementing the plan.

3. designate individuals responsible for implementing specific strategies in the plan.

4. specify target dates for accomplishment of the plan.

5. reevaluate the goals and implementation plans on an annual basis.

The undersigned agree to designate appropriate representatives to meet and address the stated goals on this agreement.

The undersigned hereby endorse this memorandum of understanding in the city of Washington, D.C. on the 24th day of February, 1986.

Acting Administrator of Veterans Affairs

President, NASVH

Chief Medical Director

Chairman VA-NASVH Liaison Committee

Assistant Chief Medical Director for Geriatrics and Extended Care

Secretary/Treasurer NASVH

Vietnam Veterans of America, Inc
2001 S St., NW
Suite 700
Washington, DC 20009-1125

(202) 332-2700

STATEMENT

OF

MARY R. STOUT
SECRETARY

VIETNAM VETERANS OF AMERICA

ACCOMPANIED

BY

RICHARD F. WEIDMAN
DIRECTOR OF GOVERNMENT RELATIONS

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

APRIL 22, 1986

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Mr. Chairman, my name is Mary Stout, and I am Secretary of Vietnam Veterans of America (VVA), having been elected to that office by the delegates to the VVA National Convention in Detroit last November. I also serve as Chair of the Veterans Affairs Committee of the National Board of Directors of Vietnam Veterans. Accompanying me here this morning is Richard Weidman, who serves as Director of Government Relations on the National Staff of VVA and is VVA's representative to the Veterans Administration Advisory Committee on Readjustment of Vietnam Veterans, having been appointed Vice Chairman of that Committee by the Veterans Administrator earlier this year. .

Vietnam Veterans of America appreciates the opportunity to appear here before you and your distinguished colleagues to present the views of our organization in regard to the vital health care issues before this Committee today.

Mr. Chairman, Vietnam Veterans of America has been consistent, throughout our existence, in our firm belief that military service is an obligation of citizenship, and not a ticket to special and privileged status within our society. The commensurate obligation of the American society is to ensure that no individual is lessened by virtue of his or her service to country in the military, especially by reason of exposure to enemy fire. We believe it is the Nation's duty, by means of the Federal Government, to make whole, insofar as possible, those who have been diminished physically, psychologically, economically, or otherwise as a consequence of their military service. In short, readjustment, rehabilitation, and restoration of combat theatre veterans is not time specific nor

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a duty from which we can shirk.

READJUSTMENT COUNSELING PROGRAM

The Congress, in passage of Public Law 98-160, has recognized the reality of the necessity of Readjustment Counseling on an ongoing basis when it directed that "the Administrator shall, within the limit of Veterans' Administration Facilities, furnish counseling to such veteran [requesting] in readjusting to civilian life (from Section 612A. "Eligibility for readjustment counseling and related mental health services.")

Vietnam Veterans of America has been a steadfast supporter of the Readjustment Counseling Service (RCS) (VET CENTER SYSTEM). VVA contends that the Vet Centers, perhaps the most scrutinized program in recent history of the Veterans Administration, is one of the most effective and cost efficient service delivery mechanisms of the Veterans Administration today. We note that when the Congress examined the RCS program in 1984, it emerged that the RCS cost per patient visit was less than half that of the Mental Hygiene Service Clinics Out-patient cost per patient visit for FY 1983 ($19 vs. $42.90). There are currently one hundred eighty nine (189) Vet Centers and satellites operating at a relatively modest cost of $40.5 million per year. These facilities are effective deliverers of critically needed mental health services to veterans and their families suffering from very real psychological wounds of war especially Post-Traumatic Stress Disorder.

Taking into account the projections for FY 86 (based on the

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first five months), by the end of this year the VET CENTERS will have served more than 400,000* Vietnam veterans since its inception at the beginning of FY 1980. This program has relieved an already overburdened VA Medical Center system by delivering the appropriate level of care that is defined as hospital care (Section 612A) with minimal permanent overhead. *See Appendix I

As with any new organization, there were in fact some problems experienced in the early days of the VET CENTERS. Thanks to the leadership provided by Dr. Arthur Blank, Director of the Readjustment Counseling Service, with the active support of Hon. Harry Walters, Hon. Everett Alvarez, and the Chief Medical Director, Dr. John Ditzler, most of those early problems are now solved. A "professionalization" of the VET CENTERS has taken place whereby a qualified mental health professional thoroughly knowledgeable in treatment of post-traumatic stress disorder (PTSD) and other war related psychic wounds is in most of the 189 sites. The success of the program has been documented many times over before this Committee, and is certainly reflected in the "First Annual Report of the Chief Medical Director's Special Committee on Post Traumatic Stress Disorder", mandated by Public Law 98-528, and dated January 25, 1985. The CMD's Special Committee noted that the heavy PTSD case load of 88 Vietnam veterans per counselor with PTSD to be "remarkable", especially in light of the fact that the "readjustment problems of the Vet Center's target population are not limited to the treatment of PTSD." "The Vet Centers have provided a combination of services within a psycho-social context that includes war debriefing, individual therapy, crisis intervention, marriage and

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family counseling, Rap groups, special outreach to minorities, vocational counseling, social service networking and community liaison." In short, the CMD's Special Committee, most of whom are medical practitioners within VA Hospitals, found the performance of their colleagues at the Vet Centers so fully satisfactory that virtually all of their recommendations (See Appendix II) had to do with improvement of the access to and quality and coordination of care delivered in the VA Medical Centers and other areas of the Veterans Administration structure. The case is clear that they believe the Vet Centers should continue as currently structured. It is the understanding of Vietnam Veterans of America that the Chief Medical Director concurs in this judgment. Moreover, the Veterans Administration Advisory Committee on Readjustment of Vietnam Veterans with the major veterans organizations represented, recommended without dissenting vote to continue the system as is, making necessary enhancements or modifications of the system as needed, to meet but not exceed legitimate requests for service. (See Appendix III).

Mr. Chairman, Vietnam Veterans of America urges you in the strongest possible terms to ensure that the Readjustment Counseling Service is continued beyond the current expiration date of September 30, 1988, and to make this decision now, so that orderly resource planning beyond FY 1988 can take place. Frankly, VVA would recommend that the Congress mandate extension of the Readjustment Counseling Service in its current form until at least 1996. We base this recommendation on the fact that there has been no significant diminishment of demonstrated request for readjust-

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ment assistance as reflected in the statistics of Vet Centers usage by new Vietnam veteran clients. Despite the one time drop in FY 85 the trend is now clearly toward increased access to vitally needed mental health care by veterans suffering from psychic wounds. VVA would also point out that a majority of VET CENTER clients are employed and contributing to their communities in economic and social ways. By being able to receive services at the VET CENTERS for problems that are either sub-clinical or mildly clinical in nature, before these problems worsened, these individuals have continued to be able to contribute to the strength of the fabric of American life. That means that the ever more professionally trained staff of the VET CENTERS is now able to concentrate more on delivering more intensive care to those individuals with more severe psychic wounds, ie those combat veterans with moderate to severe cases of PTSD, including an increasing number of patients recently discharged from VA Medical Centers and referred by some to VET CENTERS for follow up help care. Based on the available information, we are still at the height of the "bell curve" of evidenced psycho-social problems evidencing in Vietnam veterans and it is our belief that the demand for these vital services will not begin to ebb appreciably until the early 1990s.

VVA believes that the case for mandating continuation of the Readjustment Counseling Service (RCS) VET CENTERS is compelling. While VVA would prefer that the Congress mandate continuation of RCS, VVA would support the more moderate and judicious step taken in Section 2 of HR 4623, the "Readjustment Counseling Program Amendments of 1986," which essentially leaves the decision of how

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best to meet the Readjustment Counseling services mandated by PL 98-160 up to the Chief Medical Director and the Administrator. In light of the fact that the "National Needs Assessment of Vietnam-Era Veterans" is approximately 6-9 months behind schedule, and not likely to be available to the Congress in time to make a definitive judgment prior to the end of 1987, when dismantling of RCS must begin under current statute, the proposed modification strikes us as perhaps the most moderate and judicious way to proceed.

READJUSTMENT COUNSELING PROFESSIONAL FELLOWSHIP PROGRAM

Vietnam Veterans of America strongly favors Section 3 of HR 4623, which creates the "VA Readjustment Program." One of the consequences of the professionalization of the VET CENTERS, which VVA strongly supports, was that many fine counselors, who clearly have both the commitment and the natural talent to be excellent professional care providers to wartime veterans with psychological wounds, have become stymied in their advancement and development within the system. Many of these fine men and women entered the system under Veterans Readjustment Appointments (VRA) and have developed their skills through in-service training and part-time college courses, working to acquire both the clinical skills and formal credentials which would enable them to do a even better job of serving their fellow veterans. VVA would point out that these people are involved in what are literally life and death situations on a recurrent basis (the average Vet Center team spends nine hours

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per week in after hours crisis intervention.), and yet have continued to seek additional formal training. Enactment of this program would both be a symbolic recognition of the heroic sacrifices being made daily without fanfare and also serve to expand the this relatively small group of professionals who are trained, credentialed, and committed to helping heal the very real psychological wounds that are every bit as real as those inflicted by pungi stakes or shrapnel.

In order to successfully counsel combat veterans it is extremely helpful that the trained clinician be a wartime veteran. In order that the Readjustment Counseling Service be able to successfully recruit, retain and promote those individuals who have the significant credential of being a Vietnam veteran, this program is needed. There is unfortunately not a large pool of Vietnam veterans who have acquired the necessary academic and clinical skills to go with their wartime experience so necessary to successful treatment of war related PTSD counseling. This is particularly true among minorities. Therefore, the VA needs to help develop already identified talent.

Vietnam Veterans of America wishes that we could state that we are the last generation of American combat veterans. Recent events have made it clear that this may not be true. We must do better to ensure that today's and tomorrow's young veterans are properly cared for. That means having a group of trained professionals who have experienced war and are clinically capable of adequately addressing the psychic wounds of war.

Mr. Chairman, just as Vietnam Veterans of America is unequi-

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vocably for continuation and full funding of the New GI Bill authored by Chairman Montgomery as part of the legacy we, and you and your distinguished colleagues leave to the next generation, VVA urges passage of this small step in that direction.

We note that our National Convention felt strongly enough about this issue to unanimously pass a resolution calling for this program. (See Appendix IV).

Post-Traumatic Stress Disorder (PTSD) is not just a Vietnam veteran problem. It did not begin with us, and unfortunately will not end with us. PTSD is a problem of combat theatre veterans, and should be regarded as same. The literature in this regard is now overwhelming. Surely we have an obligation and a duty to prepare for caring for the wounded. This proposal is a very modest, but vital part of that preparation.

PILOT PROGRAM on HOSPITAL EFFICIENCY

Mr. Chairman, Vietnam Veterans of America favors passage of the "Pilot Program on Hospital Management Efficiency." VVA commends Chairman Montgomery for this step to attempt to discover more efficient ways to deliver effective quality care within limited resources.

VETERANS HEALTH CARE

Mr. Chairman, in regard to the "Veterans Health Care

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Amendments of 1986," Vietnam Veterans of America generally favors passage. We urge you to make clear in "Section 2, Respite Care," that care is intended to cover veterans of all generations, including Vietnam veterans without a permanent domicile who are receiving neuro-psychiatric care. Further, VVA recommends that under "Section 5, Regional Medical Education Centers" (RMECs) that the VA be required to survey RMECs to ensure that there is adequate training for PTSD and other combat related neuro-psychiatric disorders as recommended by CMD's Special Committee on PTSD. (See Appendix II).

VVA applauds the proposed increase in grants to the states for State Home Construction Grants, but recommends that it be made clear that care delivered in these facilities shall for both short and long term care and be made available to veterans of all generations.

We also recommend that the VA be mandated to make the taking of Military Service History a permanent part of the Medical Procedures Manual, to be followed by all VA facilities, in all cases, in the future. (See Appendix V and Appendix IV). Currently, this requirement is in effect only by virtue of a temporary directive in Department of Medicine and Surgery that took almost two years to secure. This seems to VVA to be a most basic step in the Veterans Administration that is committed to "he who hath bourne the battle." How shall we know who has bourne the battle if nobody asks?

Lastly, Mr. Chairman, it is the understanding of Vietnam Veterans of America that the "Policy Advisory Committee," of the

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Department of Medicine and Surgery of Veterans Administration, by a narrow margin voted on April 15, 1986 to continue the "20% discount" of neuro-psychiatric Diagnostic Related Groupings (DRGs) for at least one more year. Mr. Chairman, in another year this arbitrary and capricious application of the DRGs methodology will have ground away at the neuro-psychiatric health care elements of the VA Medical system so as to have done irreparable harm. VVA urges you and your distinguished colleagues to move to immediately suspend the "20% discount" of neuro-psychiatric DRGs for a period of one year, that the Congress may more fully explore other more proper and equitable ways of resource allocation. (See Appendix VII).

Mr. Chairman, that concludes our remarks this morning. Vietnam Veterans of America thanks you for the leadership you and your distinguished colleagues have consistently shown in doing so much to ensure quality medical care to our Nation's war time wounded. VVA is grateful also for the opportunity to present our views here today. Thank you, Mr. Chairman.

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VVA 4/22/86 APPENDIX I

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VET CENTER UTILIZATION

FISCAL YEAR	NEW CLIENTS	TOTAL PATIENT VISITS	TOTAL VETERANS SEEN
1980	28,700	78,800	28,900
1981	45,600	206,400	60,300
1982	51,000	292,900	82,900
1983	69,600	392,100	103,200
1984	75,600	417,400	114,400
1985	65,200	448,000	123,200 (Estimate)
1986*	67,600	534,000	146,900*
TOTAL	403,300	2,369,600	659,800

* Projected on the basis of the first five months of FY 1986. Year end figures may be higher as some of the 52 new Center sites are not yet at full operational capacity.

Note: Projected total cost per visit FY 1986 = $37.00
Projected cost per visit - personnel services only = $22.00.

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4/22/86

APPENDIX II

First Annual Report

of the

Chief Medical Director's

Special Committee

on

Post-traumatic Stress Disorder

January 25, 1985

Paper Prepared by:

Matthew J. Friedman, M.D., Ph.D. (Chairman)
Lawrence C. Kolb, M.D.
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Recommendations

The Chief Medical Director's Special Committee on Post-traumatic Stress Disorder has reviewed the best current information regarding the Veterans Administration's capacity to diagnose, provide treatment, conduct research, offer educational programs, and adjudicate disability claims for PTSD. As a result of this review, the Special Committee has agreed unanimously on a set of recommendations. In some cases, these recommendations call for specific actions while in others they set an agenda for future study. The justification for all recommendations can be found in previous sections of this report and will be detailed here. Recommendations will address: Resource Allocation, Clinical Data Acquisition, Improving Access to Care, Diagnosis of PTSD, Treatment, Research, Education, and Veterans Benefits.

These recommendations are made with great sensitivity to the severe budgetary pressures now facing the Nation in general and the VA in particular. The Special Committee, however, believes that since PTSD is one of the few medical disorders specifically caused by combat exposure, it should be given very high priority by the VA in competition with other programmatic requests.

I. Resource Allocation

1. Because existing VA outpatient mental health facilities are, without exception, operating at full capacity or above, and because Vet Centers were never intended to provide the range and sophistication of treatment alternatives that are only available in VA hospitals, the Special Committee recommends that two mental health professionals, including at least one psychiatrist, who is experienced in the diagnosis and treatment of PTSD be provided by centrally directed FTEE to each Medical Center to form the core staffing of a designated PTSD treatment team. These professionals will provide services at Vet Centers as well as in the hospital. This core staffing will be augmented by each Medical Center to a level to meet the clinical needs of the local PTSD patient population. The PTSD treatment team at each Medical Center will: (a) provide direct clinical care; (b) integrate treatment offered in Vet Centers, general hospital (inpatient and outpatient) programs, and special PTSD units in order to ensure continuity of care for all veterans; (c) provide consultation-liaison to medical and surgical units; (d) supervise educational programs on PTSD; and (e) monitor utilization patterns of patients with PTSD.

2. The Special Committee supports the concept of designating a PTSD treatment unit in each of the VA's 28 Medical Districts with priority according to the clinical need in a given District. As programmatic guidelines become more standardized and criteria for patient selection better understood, the Special Committee will make more specific recommendations in this regard.

II. Clinical Data Acquisition

3. The Special Committee recommends that the VA establish a reporting system capable of tracking individual patients through all aspects of their treatment (inpatient, outpatient, Vet Center and Special PTSD Units). Without such a system, it will remain impossible to assess severity, chronicity, recidivism or rehospitalization rates among patients with PTSD.

4. Better tracking of PTSD patients could be achieved by accelerating the time-table for implementation of the clinical software packages of the VA's automated data processing (ADP) system currently scheduled for completion in 1987-88. (The mental health software package is in the verification process and could be implemented almost immediately if needed resources were made available.)

5. In addition to tracking clinical utilization by PTSD patients, it is further recommended that such a data system assess treatment outcome.

6. The VA should conduct an epidemiological and demographic study of veterans with PTSD discharged from medical facilities and Vet Centers to show (a) geographical distribution of PTSD patients in comparison with the total veteran population; and (b) distribution of resources allocated for the treatment of PTSD.

III. Improving Access to Care

7. Steps should be taken to assure that adequate diagnostic evaluation be made available to each combat veteran regardless of his or her current service-connection status.

8. A systematic and standardized protocol should be developed to identify veterans 'at risk' for PTSD and applying for care.

9. Those veterans fitting the high risk profile (those with combat exposure) should be offered a clinical assessment to achieve a definitive diagnosis regardless of eligibility for care as defined locally.

IV. Diagnosis of PTSD

10. VA Medical Centers should be provided further guidance with regard to clinical assessment of 'high risk' veterans including a Professional Services Letter to include specific guidelines: (a) for screening at points of admission; and (b) for diagnosis of PTSD according to the current American classification scheme (the DSM-III).

11. Reliable and valid diagnostic rating scales should be developed and standardized. Such instruments should include: (a) self-report PTSD scales; (b) self-report combat exposure scales; and (c) standardized therapists' rating scales for PTSD.

12. Clinicians should be educated in current 'state-of-the-art' qualitative and quantitative psychological and physiological techniques for diagnosing PTSD.

V. Treatment

13. The Special Committee recommends that the VA develop and issue a Mental Health Program Guide describing the various treatment approaches to PTSD. These guidelines should address the many treatment alternatives identified in this report and delineate their applicability to Medical Center inpatient and outpatient psychiatric programs, to Vet Center readjustment counseling, and to specialized PTSD Treatment programs.

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14. It is necessary to develop criteria for referring specific patients to specific treatment alternatives; for example to identify those patients who require long-term inpatient treatment in a special PTSD unit as compared to those who may achieve maximum benefit from readjustment counseling at a Vet Center.

15. The nature of PTSD and the characteristics of definitive treatment (as opposed to generic crisis intervention) must be taken into account in the prospective funding mechanism for psychiatric care in the VA. Specific DRGs with appropriate trim points and weighted work units should be developed. 'Pass-through' funding might be a reasonable interim strategy so that present DRGs will not provide a financial disincentive to starting or maintaining specialized inpatient PTSD unit.

16. The Special Committee strongly recommends that psychiatric liaison and consultation services be properly staffed at each medical center to assure that PTSD patients are identified and offered treatment in addition to either their medical and surgical care or to their treatment for alcohol and drug dependence.

17. There should be systematic coordination and integration of all treatment resources from Vet Centers to general medical center programs to specialized PTSD units. This is essential for the diagnosis and treatment of this disorder and for the efficient utilization of all treatment alternatives.

VI. Research

18. Funding research for PTSD should remain a high priority for the VA.

19. Since PTSD is one of the few medical disorders treated by the VA that is specifically caused by combat exposure, the Special Committee believes that serious consideration should be given to making more research funds available to investigators who wish to study this disorder.

20. Efforts to increase the number of investigators and protocols studying PTSD should continue. Strategies for achieving this goal might include: (a) additional workshops on developing fundable protocols (comparable to the one held October 1984), (b) mini-residencies in research design, (c) implementation of the pre-proposal system such as that currently used by VA Health Services Research and Development, and (d) establishment of a new investigators program that would provide seed money to attract potential researchers to investigate aspects of PTSD.

21. It is necessary to ensure that all committee members on the Merit Review Board in Mental Health and Behavioral Sciences have an awareness of PTSD and that some committee members have expertise in this field.

VII. Education

22. In view of the small percentage of VA staff exposed to training in this area, the committee further recommends that the VA develop a national approach to training in PTSD. By addressing diagnostic and treatment issues, such a program should promote consistent treatment practices throughout the system. Appropriate funding and support should be provided to make such training available.

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23. The Special Committee recommends that the VA conduct a systematic assessment to determine the impact of PTSD educational programs presented in relation to the educational needs identified within the agency.

24. Faculty members both within and without the VA system should be identified who may best develop and present such programs and provide consultation at local centers.

25. Educational program initiatives should be centrally prioritized in order to influence the direction of local and regional educational activities.

26. Educational aids (audiovisual material, curriculum plans, etc.) should be updated to include state-of-the-art material.

27. The Special Committee recommends that educational activities regarding the diagnosis and treatment of PTSD should be directed toward five major audiences: VA clinical staff, VA administrative staff, military personnel, community groups and students in the health professions.

VIII. Veterans Benefits Issues

28. Because of many reports from across the country suggesting inconsistent application of regulations concerning PTSD, complaints about the conduct of compensation and pension examinations, and inconsistent adjudication and appeals decisions by the fifty eight regional offices, the Special Committee recommends, that for one quarter, each Regional Office keep track of all PTSD claims and also all other mental health claims. The specific information needed for this tabulation requested by the Special Committee is detailed earlier in this report. It includes items such as the number of claims actions completed more than 6 months after submission. Data generated during this 3 month survey would make it possible to review and identify any indications of system-wide or station specific problems affecting disability evaluations.

29. An ongoing tracking system should be established for PTSD claims similar to that established for former prisoners of war.

30. It is recommended that adjudication boards give presumptive accuracy to information contained in the clinical examination with regard to self-reports of combat exposure if it is supported by the claimants DD-214 and require verification from the U.S. Army and Joint Services Environmental Support Group only in questionable cases.

31. It is recommended that in the future there be joint training and cross training between local clinicians and local adjudicators.

32. The committee recommends that all relevant clinical information (discharge summaries, clincial notes and relevant test results) be considered by each adjudication board when processing claims rather than relying exclusively on information from compensation and pension examinations.

33. It is recommended that the Department of Veterans Benefits consider designating an administrative PTSD coordinator at each Regional Office.

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VVA 4/22/86 APPENDIX III

Veterans Administration

Memorandum

Date JAN 08 1986

From Chairman, Vet Center Planning Committee

Subj Committee Report

To Chief Medical Director (10)
THROUGH: Associate Deputy Chief Medical Director (10X)

1. Attached is the report requested by the Acting Chief Medical Director on July 26, 1984 (Attachment A). The report conveys the Committee's recommendations for the future of the Vet Center program.

2. The Committee will be pleased to carry out any further planning activities which you may direct.

Thomas P. Mullon (MP)
THOMAS P. MULLON
Director, VAMC Minneapolis

Attachments

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REPORT OF THE VET CENTER PLANNING COMMITTEE DECEMBER 30, 1985

I. BACKGROUND

At the direction of the Chief Medical Director (CMD), the Vet Center Planning Committee has been meeting periodically since January 1983, and a number of interim reports have been submitted to the CMD. The Committee has conducted a thorough review and analysis of the Vet Centers over a three-year period. This review and analysis has been in accordance with guidance recurrently furnished by the CMD. The Committee has carefully studied all relevant legislation, program data, and other material pertinent to the future of readjustment counseling for Vietnam era veterans.

In late 1984, the Committee formulated several options for the Vet Center programs future. During the deliberations of the past year, these options have been further refined. The options were furnished to all chiefs of psychiatry, psychology, and social work, and all Vet Center Team Leaders nationwide, and reactions were obtained--with a high response rate--from those individuals. In addition, in accordance with a request from the Deputy Administrator to the Department of Medicine and Surgery, the planning options have been reviewed by the agency Advisory Committee on Vietnam veterans, including representatives of the principal veterans organizations.

Our three years of deliberations, and consideration of the input as described, resulted in the Committee's recommendations which were finalized at our meeting of December 10-11, 1985 and which will be presented in the following.

II. SUMMARY OF APPLICABLE LEGISLATION

The various public laws applicable to the readjustment counseling program have not specified the organizational means by which readjustment counseling services are to be furnished. However, at the time of passage of Public Law 96-22 in 1979, the Congress understood that the agency intended to proceed through the creation of community-based Vet Centers. Within the statutory language this concept of special facilities is referenced by directing that the primary use of such facilities should largely terminate at a certain point in time--currently, October 1, 1988.

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In addition however, the most recent applicable law, Public Law 98-160 (Attachment B) removed any delimiting date on eligibility for readjustment counseling on the part of Vietnam era veterans, requiring the agency to provide such services for an indefinite period.

Also, Public Law 98-160 requires the Administrator to report to the Congress not later than April 1, 1987, on

- The effectiveness of readjustment counseling and mental health services, and outreach efforts, for meeting Vietnam era veterans readjustment needs.
- The opinion of the Administrator about the extent to which readjustment needs of Vietnam era veterans are unmet.
- The extent to which Vet Centers are needed.
- Recommendations from the Administrator to the Congress about amendments to paragraph (1), subsection (b) Title I of Public Law 98-160 which concerns the September 30, 1988 cut-off date for Vet Centers.
- Other legislative and administrative actions which the Administrator considers appropriate.

It is of note that the Congress has not required any particular means of organization and administration of readjustment counseling services on the part of the agency. The flexibility thus permitted the agency is reflected by the fact that since 1980 the organization of the readjustment counseling program has evolved from (1) an element in the Mental Health and Behavioral Sciences Services to (2) a professional service in VACO, and to (3) an element of DM&S Operations (10B). Similarly since 1980, the organization of the program in the field has been significantly re-designed by the agency.

III. SUMMARY OF RELEVANT OPTIONS

The Committee finds that there are three relevant organizational options for the readjustment counseling program in the future (For purposes of this report, these are designated as Options I, III, and V):

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Option I: Maintain the current organization and administration of the program without fundamental changes indefinitely beyond FY 1988.

Option III: Convert the program during FY 1988 to an element of the Psychiatry Services at medical facilities.

Option V: Convert the program during FY 1988 to a Professional Service at the medical facilities.

In addition, the Committee finds that under any organizational future which may be adopted, certain pilot programs may be undertaken to study the applicability of the community-based Vet Center model to the delivery of other DM&S services in addition to readjustment counseling. (Such pilot programs are described in Options II and IV in the attachments to this report, and our recommendations in regard to pilot programs are presented in Section VII below.)

COMMITTEE RECOMMENDATION-ORGANIZATIONAL:

IV. The Committee recommends to the Chief Medical Director the adoption of Organizational Option I (This recommendation is based on an 11 to 5 vote of the Committee members where eleven members recommend Option I, no members recommend Option III, and five members recommend Option V).

Thus, the key points of the Committee's recommendation are the following:

- o The present Vet Center program should be continued after FY 1988, with no major alterations in structure, services or eligibility.
- o The Committee recommends that the Administrator should at this time forward a legislative initiative to the Congress removing the concept of a general disbanding of Vet Centers during FY 1988, deleting by amendment subsection (g) (1) and (2) of 612 A and substituting language indicating that the availability of readjustment counseling services will be provided by the agency in a manner determined by the agency.
- o While maintaining the present organizational structure of the Readjustment Counseling Service and the Vet Centers, the program should be generally and gradually reduced in size, if and as the need for, and utilization of, services on the part of Vietnam era veterans decrease.

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- The contracts portion of the program should be gradually downsized, and resources re-directed as necessary to Vet Centers.

- Within the existing organizational structure, individual Vet Centers should be continued, terminated or re-located according to changing patterns of utilization. Relocations may include locating a Vet Center within a VAMC or VAOPC if desirable according to local patterns of utilization. Additionally other DM&S services may be co-located with a Vet Center.

- In the years following FY 1988, the program VACO and regional management elements should be downsized commensurate with downsizing of the Vet Center service delivery components in the field. If and as this downsizing of management elements approaches minimal levels in future years, they should be maintained as permanent readiness elements capable of responding promptly to readjustment counseling needs of veterans of future wars.

- Readjustment counseling elements at all levels and at all locations should continue the current development of full collaboration with other DM&S elements, particularly psychiatry, psychology, and social work services and with relevant DVB elements, in the provision of services.

V. DISCUSSION OF THE COMMITTEE'S ORGANIZATIONAL RECOMMENDATION:

The Vet Centers a represent a highly successful innovation in the delivery of services by the agency. The program has become a highly valued presence in most communities and has greatly contributed to the healing of the aftermath of the Vietnam War, not only in veterans but in our society generally. Several factors currently indicate that the program is highly effective, namely: (1) the continuing high utilization of Vet Centers by veterans. (2) the responses to our survey from chiefs of psychiatry, psychology, and social work; (3) the most recent evaluation of program services' effectiveness by Office of Planning and Program Evaluation, and (4) veterans service organization site visit reports.

Especially in recent years, the program has become an integral and complementary part of the overall VA health care delivery system, enhancing continuity of care and fundamentally improving the understanding of psychological readjustment tasks of combat veterans throughout the agency.

Because of the program's unique capacity to maintain highly committed and compassionate staff (a majority of whom are themselves Vietnam theatre veterans) operating in small service delivery teams, the program has achieved significantly high productivity and cost-effectiveness.

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The organizational structure and its unique features have worked to emphasize recovery, orient combat veterans towards rehabilitation and, through early intensive and client-tailored services, have probably significantly decreased morbidity and need for hospitalization.

Because of its uniquely specialized focus on the psychological and psychosocial responses to duty in a war zone, the program has directly and indirectly accelerated research, training, and improved clinical treatment of post-traumatic stress disorder and related readjustment problems throughout the VA system.

Intra-agency dissension about the innovative and distinct organization of the Vet Center program has faded in recent years, in conjunction with the program's success. This change is reflected by the fact that a plurality of chiefs of psychiatry, psychology, and social work, in response to the Committee's survey, have expressed a preference for continuing the present organizational structure. (See Attachment C which reports on the results of the field survey.)

The mission of the Readjustment Counseling program--to provide counseling for the psychological wounds of war in a context oriented towards community readjustment--is central to the mission of the Veterans Administration.

With regard to need for services on the part of Vietnam era veterans, the utilization of services in Vet Centers does not as yet show any significant decrease. The total number of visits and clients seen in Vet Centers nationwide in FY 1986 will be significantly higher than in FY 1985, because of the recently-completed opening of 52 new centers as mandated by Congress. It is clear that Vet Centers will continue to be needed for the foreseeable future, at or near current levels. Although it is to be expected that the need for services will ultimately decline, other than to say that the decline will be gradual the timetable is impossible to predict. However, the current organizational structure of the program lends itself readily to downsizing at whatever rate is indicated by a future decline in need for services.

Absent any congressionally mandated expansions, the program as is will show slight increases in resource requirements, due solely to inflationary pressures and up grading of professional level of staff, during the next few years. Such increases are not absorbable per se, because overhead and non-service-providing staff costs are minimal to begin with. However, inflationary and professionalization pressure on costs can be offset by the recommended gradual reduction in the contracts portion of the program. The program is therefore in a position to not increase dollar resources any further.

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Furthermore, it is to be expected that decrease in need and utilization of services, if and when it occurs, can be responded to promptly with net reductions in both dollars and FTE, under the present organizational structure.

Finally, the Committee's assessment is that the effectiveness of the Vet Centers, their contributions to DM&S and the quality of their services, will be enhanced by legislative removal of the concept of a general termination date.

In light of our assessment, it is recommended that the agency submit to Congress in the near future the report required by P.L. 98-160, and that an update be submitted in 1987.

For further discussion of the advantages and disadvantages of the Committee's recommended option, please see the Option I Subcommittee Report (attached).

VI. KEY POINTS OF OTHER ORGANIZATIONAL OPTIONS

A. Option III:

This option would place all readjustment counseling services under the chief of psychiatry at medical facilities as of the end of FY 1988. The Readjustment Counseling Service would be disbanded and all Vet Center employees would be transferred to the Psychiatry Services at the medical facilities. VAMC directors and Chiefs of Psychiatry would determine whether or not to maintain a community-based Vet Center. At least seven different organizational and staffing patterns within the local psychiatry service could be utilized to provide readjustment counseling services. General resource impact of this option is difficult to predict because of the wide variety of models which would be utilized by the medical facilities. In general dollar resources could theoretically vary system-wide between 78% and 139% of the program's current budget, over the next decade.

The advantages and disadvantages of this Option are fully discussed in the attached Option III Subcommittee report.

B. Option V:

This option would convert the Vet Center program to a professional service during FY 1988. The Team Leader would become a professional service chief reporting to the Chief of Staff at the medical facility.

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Services would be provided in a community-based Vet Center or within the medical facility as determined locally. The program element in VACO would become a professional service, and the program regional management component would be placed under the Regional Director to provide program guidance and assistance. This Option would establish readjustment counseling services on the same administrative basis as other DM&S services.

The advantages and disadvantages of this Option are fully discussed in the attached Option III Subcommittee report.

VII. COMMITTEE RECOMMENDATIONS ON PILOT PROGRAMS:

The Committee regards the Vet Center model as having high potential for less costly delivery of various DM&S services, other than readjustment counseling, in small, community-based sites. This would provide for early interventions in order to preclude more costly institutional care. Especially in light of increasing pressures from the aging veterans population, the demonstrated expertise of Vet Center staff in establishing community linkages and mobilizing non-VA services for veterans, should be mobilized in the interest of testing the Vet Center as a base for developing more comprehensive community based care.

The Committee therefor unanimously recommends that the Chief Medical Director direct the Office of Research and Development's Health Services Research and Development Service to establish as HSR&D pilot projects, protocols which may be submitted by individual medical center directors and Vet Center Team Leaders. Such locally-initiated pilot projects, which might commence in the near future, can be conducted entirely within existing resources. The pilot projects can provide various DM&S services suitable for a community center, with an emphasis on broad based health assessment, integrated case management, and mobilization of non-VA services for veterans. On a test basis, these projects would provide services to veterans of all eras.

The Committee's assessment is that some medical facilities and Vet Centers are prepared to take such initiatives. Our view is that such initiatives can provide an opportunity to test variations in structure, organization, and delivery of DM&S services, and would thereby greatly enhance the agency's capacity to creatively respond to the extraordinary challenges of shrinking resources which may be at hand.

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The Committee's view is that the present organizational structure of the Vet Center program lends itself well to conducting such pilot projects.

Inasmuch as such projects can be carried out with no additional resources, can be started within a short time, and may represent an excellent opportunity for DM&S to develop less costly and more effective innovations in community-based care, the Committee recommends and requests that the Chief Medical Director provide authority for such projects to be a carried out under the HSR&D format.

While the results of such pilot projects may contribute to further evolution and adjustments in the Vet Center program, the Committee recommends that that possibility should not delay implementation of its recommendation of Option I for the Vet Center program, and the submission of a legislative initiative as described in Option I, especially because these actions will provide the best context for conducting such pilot programs.

A detailed discussion of the possible pilot projects is included in the attached reports of the Option II and IV Subcommittees.

VIII. EXPANSION OF ELIGIBILITY FOR READJUSTMENT COUNSELING:

In 1984, the Senate passed legislation which would provide eligibility for readjustment counseling to war-zone veterans of World War II, the Korean War, and post-Vietnam conflict situations (e.g., Beirut, Grenada). Such veterans would thereby become eligible for services in Vet Centers. The House did not agree to this legislation in 1984.

The responses from chiefs of psychiatry, psychology, social work, and from Vet Center team leaders to the Committee's survey on the future of the Vet Center program, included the recommendation from a significant number of chiefs and team leaders, that eligibility for readjustment counseling services should be extended to veterans of other wars.

In recent years, in response to wider public knowledge of the Vet Centers, combat veterans of other wars have at times come to Vet Centers, and expressed a wish for counseling which included a re-examination of their wartime experiences.

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At this time there is considerable opinion amongst Vet Center staff that some (probably a small number) of combat veterans of World War II and Korea need and would benefit from readjustment counseling in Vet Centers. It is important to note that since Vet Centers began in 1980, there has been a general reconciliation between veterans of Vietnam and earlier wars, which has also been manifested by an increasing number of older combat veterans volunteering at Vet Centers.

The Committee does not recommend any legislative initiative at this time to expand readjustment counseling eligibility to other than Vietnam era veterans. However, the Committee recommends that separately from the other recommendations contained in this report, the Chief Medical Director direct relevant officials of DM&S to carefully study this issue, with a special effort to determine what, if any, resource impact such an extension would have.

IX: SUMMARY OF COMMITTEE RECOMMENDATIONS:

A. Proceed with organizational Option I as described in section IV above.

B. Provide authority and direction to HSR&D to establish pilot projects as described in section VII above.

C. Direct relevant DM&S officials to determine the desirability and resources feasibility of an expansion of readjustment counseling eligibility to combat veterans of eras other than Vietnam.

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VVA 4/22/86 APPENDIX IV

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1985 Resolution

V-5 READJUSTMENT COUNSELING FELLOWSHIP

BACKGROUND: The Vet Center system was created in 1979. The first centers opened in late '79, and Vietnam veterans were hired and trained hurriedly. In the past few years there has been a concerted effort, supported by Vietnam Veterans of America, to ensure that there is proper administration of each Center and at least one clinician in each center who has formal clinical degrees and specific training in treatment of Post-Traumatic Stress Disorder (PTSD). There are two basic elements to any successful Vet Center operation: that the Vet Center be well and properly administered by persons who have the clinical skills to help Vietnam veterans recover from PTSD, and that each Vet Center, and the Vet Center system, promulgate an atmosphere of trust between Readjustment Counseling Services (RCS) personnel at all levels, between the Vet Center and the community, and between Vietnam veterans who come to the Center seeking assistance which can best be obtained by having trained Vietnam veterans on staff.

This atmosphere of trust is essential to the success, indeed the very survival of the Vet Center system. That trust has been eroded for a variety of reasons, not the least of which is that many Vietnam veterans who were good outreach counselors have left the RCS system, both voluntarily and involuntarily because of lack of formal training. There is also a need to re-establish a sense of common purpose, teamwork, and trust within the RCS system.

BE IT RESOLVED, that the Congress be urged to create a Readjustment Counseling Fellowship to provide 100 Vietnam veterans, who have or are currently working within the RCS or similar programs in the VA or elsewhere, with higher education grants while employed in the RCS in order to obtain a clinical counseling degree. Selection would accentuate commitment, military service in Vietnam, and contain a special emphasis on minority veterans, especially Black veterans. Recipients would receive full salary while attending school and in turn would formally contract with the VA for two years of future service with the RCS.

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VVA
4/22/86

APPENDIX V

Department of Medicine and Surgery
Washington, D.C. 20420

February 24, 1986

TO: Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, and Regional Offices with Outpatient Clinics

SUBJ: Documentation of Military History in the Medical Record

1. PURPOSE: This DM&S Circular is a reissue of expired DM&S Circular 10-83-13 that includes changes.

2. POLICY: Military history information is a required data item of the SF 505, History - Part 2. It should be documented in sufficient detail to assist in providing an accurate diagnosis of any current medical or psychiatric problem in order to formulate treatment.

3. ACTION: This Circular is to provide more pertinent guidelines for the documentation of information pertaining to the military history of veterans.

4. RESCISSIONS: DM&S Circular 10-83-13 dated January 19, 1983.

5. FOLLOW-UP RESPONSIBILITY: Associate Director, Mental Health and Behavioral Sciences Service.

John A. Gronvall, M.D.
JOHN A. GRONVALL, M.D.
Deputy Chief Medical Director

Attachment

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TYPING: 1 SYMBOL SHEET 8½ X 11 THIN (Type within blue lines)

THIS CIRCULAR EXPIRES ON FEBRUARY 23, 1987

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VVA 4/22/86 APPENDIX VI

Vietnam Veterans of America, Inc.
2001 S St. NW
Suite 700
Washington, DC 20009-1125

(202) 332-2700

1985 Resolution

V-8 VAMC MILITARY HISTORIES

BACKGROUND: About 10% of all veterans seen at Vet Centers each year require in-patient neuro psychiatric care. In order to properly diagnose and treat Post-traumatic Stress Disorder (PTSD), and other combat related neuro-psychiatric problems of veterans in VAMCs one must know in some detail the military history of an individual, particularly the "stressors" that led to the neuro-psychiatric illness. The Chief Medical Director issued a Department of Medicine and Surgery Circular in January, 1983 mandating that service histories be taken from all veterans admitted to VA Medical Centers. This circular, which was not widely enforced, expired in January 1984. Currently there is no requirement that the VA obtain a military history, even where it is clearly indicated. This can result in misdiagnosis of veterans of all generations suffering from PTSD and in inappropriate treatment.

THEREFORE BE IT RESOLVED that the VA require a permanent full and complete military history for every veteran admitted to a VA facility; and

BE IT FURTHER RESOLVED that the VA review and correct the systemwide problem of non-therapeutic over-medication of neuro-psychiatric patients in VAMCs, as well as out-patients; and

BE IT FURTHER RESOLVED that the VA train all psychiatric and allied health professionals within the VA system in the proper diagnosis and treatment of PTSD and other aspects of veterans' mental health treatment modalities; and

BE IT FINALLY RESOLVED that the Congress take timely action to mandate creation of at least one thousand such dedicated PTSD beds, before the end of the 99th Congress, and to provide for major resource allocation incentives for VAMC Directors to form dedicated PTSD units.

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VVA APPENDIX VII

Vietnam Veterans of America, Inc.
2001 S St., NW
Suite 700
Washington, DC 20009-1125
(202) 332-2700

1985 Resolution

V-7 DRGs AND PATIENT CARE

BACKGROUND: For many years, the Veterans Administration (VA) allocated its personnel and funds on an historical basis. This did not, however, take into account demographic shifts in the veterans population nor its changing needs. To make this system more flexible, VA developed the Resource Allocation Methodologies (known as the RAM system). This RAM includes several distinct methodologies, which include Diagnostic Related Groups (DRGs). However, the result of the use of this system is disturbing, as decisions concerning admission and discharge of patients from VA medical facilities are today being made based on institutional and budgetary considerations, rather than clinical judgments as to what is in the best interest of the patient.

The DRG model was developed at Yale University as a research model, not as a practical instrument for making fiscal decisions that are literally life and death decisions.

THEREFORE, BE IT RESOLVED, that the Congress and the VA suspend application of the DRG system to neuro-psychiatric care immediately, and restore final and proper resources to this critically vital area; and

BE IT FURTHER RESOLVED, that Vietnam Veterans of America favors reasonable and sensible allocation of resources, but opposes the current inadequate RAM system which will preclude delivery of quality health care for Vietnam veterans, under the guise of "rationality."

BE IT FURTHER RESOLVED, that Vietnam Veterans of America believes that the RAM/DRG system, inappropriately redistributes resources at the expense of service-connected disabled veterans, and can only result in "Care Second to All," especially neuropsychiatric care.

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Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

on

HEALTH LEGISLATION

April 22, 1986

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STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
APRIL 22, 1986

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates this opportunity to express its views on the several issues contained in three draft measures, relating to health care for veterans, that are under consideration today.

The first draft would establish a pilot program to determine the effect of providing the Directors of five VA medical centers with the authority to waive or alter such laws and regulations applicable to the management and administration of the medical center, as may be authorized by the Administrator, on the efficiency and economy of VA medical center management. The Administrator would be required to submit an annual report to Congress on the status of the plan, and the pilot program would expire on September 30, 1989.

It is our understanding that the intent of this proposal is to allow greater fiscal management flexibility by providing the five VA medical center directors who would be involved in this project with the authority to manage all of their resources in the manner they see fit. For instance, funds that ordinarily would be earmarked for supplies and materials could be used to fill staff vacancies, or monies appropriated for printing and reproduction could theoretically be used for education and training programs

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if the need for such were felt to be greater by medical center management. It is our belief that the findings of a pilot program such as the one set forth in this proposal would be enlightening and useful, particularly at a time when the Veterans Administration is faced with austere funding and deficit ceilings. Autonomous fiscal management, if carried out in a responsible manner, could well prove to be a solution to a substantial number of local funding problems. However, here we must introduce a caveat into consideration of this proposal. And that is the possibility that a VA medical center director could channel funds to a "pet project" under the sweeping nature of the language contained in the discussion draft. Such an initiative could have a negative impact on the provision of medical care to the veteran patients and would be totally unacceptable to The American Legion. We would like to think that such a thing would not occur, but the possibility does present itself. We recommend the language of the legislation should clearly state the intent of this proposal, so as to prohibit this kind of opportunity from arising.

The next draft is titled "Veterans Health Care Amendments of 1986".

Section 2 of the measure would amend section 610(a) of title 38, United States Code, to include respite care among the categories of care that may be furnished within the limits of the Veterans Administration to veterans deemed to be eligible under that section.

Section 601 of the title would also be amended to include the

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definition of respite care. "Respite care" in the act is defined as: hospital care or nursing home care furnished in a Veterans Administration facility on an intermittent or temporary basis to a veteran who has been diagnosed as suffering from a chronic illness and who is receiving care in the individual's home; or in a hospice program which has entered into a cooperative agreement with the Veterans Administration to provide appropriate care for the veteran.

The American Legion is very much in favor of making respite care a permanent program. Respite care is one of the innovative treatment techniques and modalities that can be used to make the VA medical care system more cost-effective, and able to care for the largest number of patients. The trend in modern medicine is to keep patients deinstitutionalized and in a family or community setting as much as possible. This enhances the quality of life provided the patient, and is the most cost-effective method of practicing modern medicine. Equally important with respect to veterans who are terminally ill, respite care is of great help to the family members, as it supports their ability to provide comfort and care during the terminal phase of the illness.

Section three of this proposed measure would amend section 632 of title 38 by extending for three years - until September 30, 1989 - the period during which the President may authorize the Administrator to enter into contracts with the Veterans Memorial Medical Center in the Philippines to provide for the care and treatment of United States Veterans.

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The American Legion is supportive of this provision.

Section 4 would amend section 4118(g)(2)(C) of the title by extending the period of time the Administrator must report to the President, with respect to recommending appropriate amounts of special pay for Veterans Administration physicians and dentists, from every two years to every four years.

We have no objection to this proposed change.

Section 5 would make permanent the program under which the Administrator designates VA medical centers as Regional Medical Education Centers. In addition, flexibility would be added to the types of medical and related education programs provided, and the personnel eligible for training under this program, through the elimination of restrictive language.

The American Legion is agreeable to this change.

Section 6 merely clarifies the period of obligated service under the Veterans Administration Health Professional Scholarship Program in the case of participants who are part-time students, and we have no objection with the proposed change.

Section 7 would provide technical changes to clarify the language relative to the sharing of Veterans Administration and Department of Defense health care resources. In addition, it would authorize the director of a VA medical care facility to enter into a sharing agreement with the commander of an Armed Forces unit located in an area in which a Department of Defense medical facility is not reasonably available. The Administrator and Assistant Secretary of Defense for Health Affairs would be directed

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to establish necessary procedures for sharing agreements in such an instance, to be as similar as practicable for sharing agreements between medical facilities.

The American Legion realizes the benefits to both agencies with respect to VA and DOD resource sharing, and is generally supportive of the proposed amendment. However, it is necessary that we reiterate our concern that no veteran with service-connected disabilities should ever be deprived of treatment in a VA medical care facility by reason of a VA/DOD sharing agreement.

Section 8 of this proposal would substantially revise the manner in which the State Veterans' Home Construction Grant Program is administered by VA.

The first proposed change, to section 5033 of the title, would provide specific authorization of appropriations of $50 million, $60 million and $65 million for fiscal years 1987, 1988 and 1989, respectively. Under current law, there is no specific monetary amount set forth in the authorization of appropriations. The language states "such sums as may be necessary".

The second substantive revision would amend section 5035 of title 38 to establish a method by which grants would be made according to the priority of the projects. It would determine when a State receives a grant and the amount that the grant should be.

Under this proposal, a State that files a preapplication with the Veterans Administration for a grant prior to October 1, 1986, would be considered for funding in accordance with current procedures

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which is a first come - first served basis. However, the State would have to complete the formal application process by October 1, 1987 in order to maintain its status under current law.

States filing preapplications on or after October 1, 1986 would be subject to the new ranking process. The factors that would be used to rank the applications would be the projected number of veterans who may apply for admission to the facility; the presence of other VA facilities available to provide nursing home or domiciliary care in the geographic area of the proposed project; the number of other facilities which may be available to provide such care; and such other matters as the Administrator considers appropriate. In addition to authorizing the ranking of planned projects, the proposal would give the Administrator the option of providing a lesser amount of funding than what is sought by a given State.

The American Legion sees no reason to support such a sweeping change to a program that appears to be operating efficiently under provision of current law.

Section 9 would make clarifying amendments to improve the Medical Facilities Sharing Program under Chapter 81 of title 38, and we have no objection to these changes.

Mr. Chairman, the last draft measure that we shall address is certainly in no way the least important, as its purpose is to improve readjustment counseling for Vietnam-era veterans.

Section 2 of the proposal would amend section 612A(g)(1) of title 38 by eliminating the date (September 30, 1988) by which the

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transition of the readjustment counseling program from the Vet Centers into VA medical care facilities is to be accomplished.

The readjustment of Vietnam veterans continues to be a priority issue of The American Legion. The Vet Center Program since its inception, has played a major role in providing readjustment counseling, referral services, individual therapy, marriage and family counseling, crisis intervention, vocational counseling and several other psycho-social services to Vietnam veterans who have not totally completed their post-Vietnam recovery and readjustment processes.

In addition, Vet Centers work closely with most if not all of the 13 existing inpatient post-traumatic stress disorder units. The Vet Center staffs refer many Vietnam veterans with severe PTSD to inpatient units, and following their discharge from a structured treatment program, provide the veterans with aftercare for a prescribed period of time - in most cases a year or more.

Based on the initial findings of the Columbia University and American Legion Vietnam Veterans Study, we are aware that many Vietnam veterans continue to pay a real price for their military service. The findings are based on analysis of data received from nearly 7,000 members of the Legion who served during the Vietnam war. Approximately 40 percent of this group served in Vietnam.

Thus far, we found that 38.7 percent (1,079) of the veterans who served in Vietnam stated that they had either experienced a mental, nervous or emotional breakdown, or had at some time following service felt they would.

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In analyzing the effects of combat on the veterans in the study population, we have found that the average annual income of those involved in the heaviest combat situations is $3,000 to $5,000 less than their noncombat peers who are the same age, and who have attained the same educational levels.

The divorce rate of those involved in the most intense fighting is over twice that of the group that saw little or no combat, and the number of Vietnam veterans in the heavy combat group that have been divorced two or more times is double the rate of the comparison group.

Another aspect of this study is the examination of health and general well-being in relation to combat and other service factors. These are under investigation and will be reported separately at a later date. However, we can tell you that the comparative data on self-reports of general health status and on life satisfaction and happiness show highly significant differences among those Vietnam veterans who were in the heaviest combat situations, compared to the light combat or noncombat groups. Their general health reports more closely resemble men ten to twenty years older who did not see combat.

We mention these findings, Mr. Chairman, to emphasize the concern of The American Legion over the fact that a number of Vietnam veterans, many of whom seemingly made a successful transition from military life back into civilian society, have later manifested varying degrees of psychological and socioeconomic distress. Other veterans, as previously mentioned in this

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statement, have never totally completed their post-Vietnam recovery and readjustment processes. However, the Vet Center Program has been a major factor in the treatment of Vietnam veterans with diagnosed PTSD, and others with identifiable symptoms of PTSD who do not meet the DSMIII criteria; and in providing counseling and numerous other services that we previously listed.

Because of the obvious need for these valuable services, and the continuing influx of Vietnam veterans seeking assistance through the Vet Centers, The American Legion supports the extension of the Vet Center Program for as long as there is a demonstrable need.

Section 3 would establish a Veterans Administration Readjustment Counseling Professional Fellowship Program for the purpose of assisting in the provision of an adequate supply of trained professionals to furnish readjustment counseling service to veterans. To be eligible to participate in the Fellowship Program an individual would have to be a Vietnam era veteran who was accepted for enrollment in an accredited course of training that leads to a post-baccalaureate degree in a field that is appropriate to furnishing readjustment counseling. At the time of application, the individual would be required to sign a written contract to accept payment of the scholarship and to serve as a readjustment counselor with the Veterans Administration for two years after completion of the course of training.

A scholarship awarded under the Fellowship Program would be

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paid in the same amount and in the same manner as scholarships under the Veterans Administration Health Professional Scholarship Program.

As with the fact there is a continuing need for readjustment counseling, there also exists a requirement that a sufficient number of professionals who are appropriately trained in counseling skills be available to carry out this program at present and at such time that the Readjustment Counseling Service is phased into VA medical care facilities.

We understand that the intent of the proposed Fellowship Program is to provide the availability of additional appropriate training to current employees who do not hold graduate degrees, as well as other interested individuals, in order to ensure that there is an adequate number of professionally trained readjustment counselors in the VA system. In addition, the program would serve as a tool for the recruitment and retention of employees in the VA Readjustment Counseling Program, in the same manner in which the Health Professional Scholarship Program has provided an incentive to ensure an adequate supply of trained physicians and nurses.

The American Legion supports the enactment of this proposal. However, it is noted that the proposal does not contain any provision for the appropriation of funds to make payments under the Fellowship Program, thus we question whether or not there would be an availability of funds under which to carry out the program if it were enacted.

Mr. Chairman, that completes our statement.

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STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE VETERANS AFFAIRS COMMITTEE
April 22, 1986

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans and its Ladies Auxiliary, I am pleased to have the opportunity to appear here today to discuss various issues relating to the Veterans Administration's health care system.

Your letter of invitation requested our views on three measures (two of which have yet to be introduced in the Congress):

* a draft bill to establish a pilot program for the improvement of the efficiency and economy of Veterans Administration medical centers;

* H.R. 4623, a bill to improve readjustment counseling for Vietnam Era veterans; and

* a draft bill to improve the delivery of health care services by the Veterans Administration, and for other purposes.

Management of Veterans Administration Medical Centers

This initiative, Mr. Chairman, proposes to establish a pilot program, within the Veterans Administration's Department of Medicine and Surgery (DM&S), for the express purpose of determining the potential efficiency and economy of the management of VA medical centers.

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As constructed, this proposal would direct the Administrator to designate five (5) medical centers to participate in the pilot program. The directors of the designated medical centers would be authorized to waive or alter laws and regulations that would otherwise be applicable to the management and administrative functions of the medical center.

As we understand it, Mr. Chairman, all laws and regulations relating to eligibility of veterans to receive needed VA medical services would remain intact and not be subjected to discretionary waiver or modification by the medical center director.

Our reading and interpretation of this draft measure would limit the director's authority to waive or alter laws and regulations only as they may apply to existing constraints or specific limitations imposed by Congressional directives and actions.

Mr. Chairman, so long as otherwise eligible veterans -- especially service-connected disabled veterans -- are not denied or postponed needed medical treatment and/or services, we have no objection to enactment into law of this draft bill.

We feel it vital, however, that a clear explanation of the intent of this measure -- to remove certain Congressional constraints on management and administrative functions -- be contained in report language so there will be no room for doubt or controversy regarding veterans' continued eligibility under existing law and regulation for the provision of needed medical services.

H.R. 4623

Section 2 of this bill proposes, through appropriate amendment of Section 612A(g)(1), Title 38, United States Code, to repeal that provision of law requiring the transition and

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integration of readjustment counseling services -- commonly referred to as Vet Centers -- into existing VA medical facilities by October 1, 1988.

In our view, this measure would, in effect, establish Vet Centers as permanent, separate entities within the framework of the VA health care system.

Section 3 of the bill would amend Chapter 73 of Title 38, United States Code, by adding a new Subchapter -- Subchapter V -- establishing a Veterans Readjustment Counseling Professional Fellowship Program.

As stated, the purpose of the program is to assist the VA in providing an adequate supply of trained professionals to furnish readjustment counseling services to veterans for the Veterans Administration.

Mr. Chairman, the DAV opposes the enactment of H.R. 4623.

Although the VA's Psychological Readjustment Counseling Program had a slow and tremulous beginning, in our view, the VA's Vet Centers have generally proven themselves to be successful in assisting Vietnam veterans and their families.

While we believe the program is necessary and will be utilized by veterans of the Vietnam Conflict in the future, we continue to strongly support the current concept -- embodied in Section 612(A) -- that the VA must plan to integrate these services into the mainstream of traditional health care services in VA medical facilities.

As you are aware, Section 101(b) of Public Law 98-160 required (in part) the VA, not later than April 1, 1987, to submit a report to the Veterans Affairs Committees of the House and Senate regarding the Administrator's evaluation of the

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effectiveness of the VA in helping to meet the readjustment needs of Vietnam Era veterans.

In view of the fact that this report is not yet completed, we feel that any proposal to establish Vet Centers as a permanent entity in the VA's health care system is premature.

We are unaware of any documented shortage or recruitment difficulties of trained professionals to furnish readjustment counseling services to veterans within the VA. Therefore, we see no compelling reason to support Section 3 of the bill.

Improvements in the Delivery of Health Care Services By the Veterans Administration

Section 2 of the draft bill would authorize the VA to provide respite care to veterans suffering from a chronic disease who are receiving care (a) in the individual's home; or (b) in a hospice program which has entered into a cooperative agreement with the Veterans Administration to provide appropriate care for the veteran.

As you know, Mr. Chairman, respite care is a relatively new concept in the array of long term care services. Generally stated, respite care is capable of providing a wide range of services that offer a degree of relief to the spouse or primary care giver who has assumed the responsibilities of caring for a veteran diagnosed as suffering from a chronic illness.

Disabled veterans may be provided with short term, intermediate or temporary stays at VA facilities in order to provide the primary care giver with a "break" from providing constant care and monitoring of the veteran.

It is our opinion that this type of alternative approach will not only provide incentives for principal care givers to

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continue to provide necessary care in the home, but will also contribute to a reduced incidence of hospital and nursing home admissions for otherwise necessary long term care.

For these reasons, Mr. Chairman, we favor enactment of this provision.

Section 8 of the draft measure proposes to make certain revisions in the State Extended Care Facilities Construction Grant Program.

As you know, Mr. Chairman, this program provides grants to assist states to acquire or construct state home facilities for furnishing domiciliary or nursing home care to veterans and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home or hospital care to veterans in state homes.

Without question, Mr. Chairman, the domiciliary, nursing home and hospital care provided to this nation's veterans by state veterans homes has been invaluable in terms of offsetting the severe losses suffered by the VA's health care system.

Recognizing the significant and important role of state veterans homes -- in terms of care provided to the rapidly aging veteran population and the cost effective use of federal taxpayer dollars that supplement this program -- we believe it is indeed wise to continue funding this program that ultimately produces savings to the government in terms of both construction and health care costs.

While we generally favor enactment of this provision, we are nevertheless concerned with the proposal to require the VA to assign a priority to each application received from a state seeking a grant for construction, expansion, remodeling or altering existing buildings of state home facilities.

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ecifically, we find no compelling circumstances that would compt us to support a major change in an established and apparently effective program that has otherwise funded projects in what appears to be an equitable and appropriate fashion.

Finally, Mr. Chairman, while we have not been mandated by our membership to pursue or support legislation regarding certain objectives contained in this draft legislation we are generally supportive of their enactment. Specifically, those provisions which address:

* extension of authority to provide medical care in the Republic of the Philippines;

* reporting period for reports on special pay for Veterans Administration physicians and dentists;

* regional medical education centers;

* periods of obligated service under the Health Professional Scholarship Program;

* sharing agreements with Department of Defense and military units; and

* improvements to the medical facilities sharing program.

Mr. Chairman, this concludes my statement and I wish to again thank you and the members of the Subcommittee for allowing us this opportunity to express our views on these important subjects.

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VETERANS OF FOREIGN WARS OF THE UNITED STATES

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITAL AND HEALTH CARE
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

PROPOSED LEGISLATION TO REVISE AND EXTEND VETERANS' HEALTH CARE PROGRAMS

WASHINGTON, D.C. APRIL 22, 1986

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the Veterans of Foreign Wars of the United States, I would like to thank you for the privilege of appearing before this distinguished Subcommittee so that we may present our views on proposed legislation which would refine the Veterans Administration's health care delivery system's ability to enhance its educational and service delivery capabilities. We are pleased at being afforded this opportunity to contribute in this area of fundamental importance to the delivery of high-quality health care to veterans.

We will present our views on these various proposals in the same order in which they are presented on the list of legislative proposals which accompanied our invitation to testify before this Subcommittee. We do this in order to present our views as clearly and exactly as possible, not to indicate their relative merit or priority.

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Proposal 1 would change the calculation of employment time owed the VA for part-time students under the Veterans Administration's Health Professional Scholarship Program. This change would require six months of full-time VA employment for each calendar year or part of a calendar year of scholarship support, in place of using the proportion that the number of credit hours carried by a participant in any school year bears to the number of credit hours required to be carried by a full-time student as is currently called for in 38 U.S.C. 4142. The VFW favors this proposal inasmuch as it would provide a fair and easily administered system of reimbursement for VA scholarship aid. We would point out, however, that this may tempt participants in the program to keep their credit load just below a full-time level in order to obtain almost a full education for only half the obligation of service.

Proposal 2 would make permanent the VA's Continuing Medical Education Program and also clarify certain aspects of the Regional Medical Education Center Program by allowing joint sponsorship of training programs, joint sponsorship of students, nonresident training, and training for other than direct health care providers. The VFW strongly supports this proposal of making permanent the VA's Continuing Medical Education Program and its Regional Medical Education Center Program. Inasmuch as it is absolutely essential to provide State of the Art medical care to veterans, it is quite clear that training must be a permanent fixture in all aspects of health care delivery.

Regional Medical Education Centers (RMECs) were established as a pilot program in 1972 under Public Law 92-541 for training medical and health personnel at Regional Medical Education Centers in geographically dispersed parts of the United States. It should be pointed out that there are now seven RMECs responsible for developing and coordinating health care training

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programs tailored to VA needs such as PTSD, Agent Orange and ex-POWs just to name a few. Last year alone, many thousands of hours of health care training were given by RMEC personnel. Significantly, the participant unit cost, adjusted for inflation, has dropped from $367 in 1979 to only $89. Quite clearly, characterizing RMECs as being a pilot program is totally inappropriate. Further, the only aspect of the program which can now be accurately termed experimental is the ongoing testing of new training methods and cost reduction techniques. And this is one form of experimentation which we completely support. The proposed legislation would also liberalize the restrictions on how training is carried out and for whom. The VFW supports this liberalization inasmuch as it would allow for enhanced training methods and for training essential members of the Department of Medicine and Surgery team such as engineers, housekeeping personnel, data processors, food handlers, among others. The VFW also favorably notes a technical clarification contained in this proposal calling for full reimbursement for participation in RMEC programs by on-VA personnel. This would enable RMECs to extend training opportunities at non-RMEC locations to community participants without incurring any additional costs. We believe this will bolster the health care afforded within individual communities while establishing a beneficial exchange of information and rapport between the VA and other local health care providers. Thus, this legislative initiative enjoys strong VFW support.

Proposal 3 would extend for three years the authority of the VA to enter into contracts with the Veterans Memorial Medical Center in the Philippines for care of the U.S. veterans. We would point out that we have a large number of service-connected veterans in the Philippines and can also expect that the nonservice-connected load will increase. We believe that this veterans'

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medical center is, in fact, about the best medical facility in the Philippines and that providing health care to veterans at this hospital is preferable to providing such care on a fee basis. Thus, this proposal enjoys VFW support.

Proposal 4 would make more flexible the authority of the VA to share medical facilities, equipment, and information with community facilities. We favor this proposal since it would not only lead to a beneficial exchange of information between the VA and the medical community at large, but also represents a cost-effective means of providing certain medical and laboratory capabilities not always available through the VA at a given location. It is our belief that the enactment of this proposal would better enable the VA to achieve the Congressional purpose stated in 38 U.S.C. 5051 of improving "the quality of hospital care and other medical service provided veterans under this title." So long as this does not lead to the wholesale privatization of the means of providing veterans' health care, we believe that it it high time to begin to secure more than just "specialized" medical resources from the non-VA health care community.

Proposal 5 would clarify the VA's authority to provide "respite" care services. Respite care, a relatively new concept in this country, provides the benefits of home care and that sometimes necessary care which can only be provided by a medical facility. We view this proposal as a compassionate step for both the veteran and his family. We would point out that respite care is not only often the best form of heath care by providing the best aspects of institutional and home care, but it is also cost-effective. Many veterans would end up permanently institutionalized instead of only occasionally occupying a bed at a VAMC without this form of care. While the VA has

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experimented with the feasibility of respite care, current law does not clearly indicate when it might be authorized. This proposal, if enacted, would effectively eliminate this discrepancy.

Proposal 6 would extend for three years the program for grants to states for construction, remodeling or renovation of state-home facilities and would also liberalize the application approval process. This includes eliminating the requirement that the grant not exceed 65 percent of the estimated cost of construction. The VFW has stated in testimony that increased funding for this program would assist the VA in reducing the number of backlogged applications on hand from the states and should, most importantly, result in more extended care beds being available sooner. Thus, the VFW supports this proposal. We place special emphasis, however, on properly and carefully implementing the section of this particular legislative proposal to be used in "determining the relative need for a project" by the Administrator. This is essential toward the most effective use of precious dollars and ultimately best serving the veteran patient. Although we favor the removal of the 65 percent limitation on how much money the VA may provide a given state, we are concerned that this could in some instances lead to the VA's having to bear a inordinate amount of the cost of some construction or, indeed, of unnecessary construction.

Proposal 7 would amend the procedures for disciplinary boards and grievance procedures for title 38 employees. It is our understanding that 38 U.S.C. 4110 would be amended so that disciplinary boards will only make determinations of disciplinary actions which would result in the person involved being removed, suspended for more than 14 days or given a demotion involving the loss of grade or pay. Although the VFW has no objection per se to refining the VA's disciplinary process and procedures, we would point out that disciplinary boards and grievance procedures for title 38 employees have

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been very effective over the years. They have provided due process while delivering sound decisions. Therefore, we can only recommend extreme caution and meticulous oversight of the implementation of this proposal.

Proposal 8 would clarify the authority for a VA medical facility and a DOD military unit or DOD medical facility to enter into a VA/DOD sharing agreement. As we have stated in previous testimony, the VFW believes that such arrangements may well benefit both the Veterans Administration and the military. We will be closely watching the pilot project between the Air Force and the VA in Albuquerque, New Mexico wherein a portion of one floor, approximately 40 beds, will be reserved for Air Force use and staffed by Air Force personnel. Hopefully this project, and others like it, will serve to provide those special services not usually found in either military or VA Medical Centers alone. Therefore, the VFW supports this proposal which would clarify the authority necessary to pursue this advantageous arrangement.

Proposal 9 would extend to four years the interval for the VA to report on special pay comparability for VA physicians and dentists. Our medical consultant has informed us that such an action would be totally appropriate; therefore, we support this proposal.

Proposal 10 would delete the requirement for transition by September 30, 1988 of the Readjustment Counseling Program from a program primarily of "storefront" services delivery to services delivered primarily through VA health care facilities. The VFW values the significant role that the Readjustment Counseling Program plays in providing services to disadvantaged veterans. The veterans seen in these Vets Centers have a high percentage of substance abuse and unemployment problems. Further, recent studies have linked these particular difficulties with Vietnam Theater veterans, that is, those veterans who have seen actual combat. Thus, these Vets Centers serve an

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especially vulnerable and deserving segment of the veteran population. Vet Center usage has been increasing by approximately 1,600 new clients a month. So, it is evident that the need for readjustment counseling is increasing. Therefore, we support this proposal which would appropriately make this particular service delivery component a permanent part of the Department of Medicine and Surgery structure.

Proposal 11 would authorize the creation of a Vietnam Veterans' Readjustment Counseling Professional Fellowship Program. This Fellowship Program is to assist in providing an adequate supply of trained professionals to furnish readjustment counseling services to veterans. It would be open to all veterans who served in the active military during the Vietnam Era and who are enrolled in a full-time course of training at an accredited educational institution leading to a post-baccalaureate degree in a field that is appropriate to furnishing readjustment and counseling services. Additionally, an eligible veteran who is only a part-time student in an appropriate course of training may also be a participant in the Fellowship Program if he is a full-time employee of the Veterans Administration. We are in agreement with this particular aspect of the proposal since we feel that preference should be given to all full-time VA staff, allowing them to continue within their chosen career field while training to better perform in that capacity. Taken in its entirety, we believe that such a fellowship program certainly has merit. There is a demonstrated need for continuing professional education within this area. Further, we believe that this Program should not be restricted to the specific attainment of advanced degrees, but should include a mechanism to allow an individual to obtain a baccalaureate degree. In administering the program, while providing appropriate preference to VA personnel, all eligible veterans should be considered, reviewed and accepted based upon merit and

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individual participation to enhance the overall program. We can see where this Program should be of great direct and indirect benefit to veterans and the Veterans Administration and, therefore, enjoys VFW support.

Mr. Chairman, I would once again like to thank you for having afforded the Veterans of Foreign Wars the opportunity to present its views on these issues. This concludes my statement.

I would be happy to respond to any questions that you may have.

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PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

R. DENNIS SMURR, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE VETERANS' HEALTH CARE AMENDMENTS OF 1986

AND OTHER LEGISLATIVE PROPOSALS

APRIL 22, 1986

Mr. Chairman and Members of the Subcommittee, I am Dennis Smurr, Associate Legislative Director for Paralyzed Veterans of America and on behalf of the members of PVA, it is my pleasure to present to you our views and concerns regarding the legislative proposals being discussed today. I should point out that our testimony will not seek to address all the bills or all aspects of each bill, rather we will restrict our comments to those specific matters that have direct implication in meeting the unique needs of our membership.

That being said PVA will defer to the judgement of the professional staff of this Subcommittee and to the working knowledge which our fellow veteran service organizations have in these other areas to assess the implications

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therein. Our primary consideration today will center upon those issues of respite care, the proposed revision of the state home construction program, and the pilot program to encourage efficiency and economies within certain VA medical centers.

Before going into the specifics of the above mentioned proposals, PVA would like to commend you, Chairman Edgar, for your untiring devotion and leadership in trying to continually improve both the quality and delivery of what we consider to be the most important benefit provided veterans -- that of adequate health care. No other veteran benefit better symbolizes this country's commitment and concern for the welfare of those who answered the call of duty in defense of the ideals of this great nation. No other veteran benefit carries with it the enormous investment in physical facility and human work force, all of which benefits not only the veteran it is designed to serve, but also the economic well-being of the communities in which the VA facilities are located, and the overall viability of the nation's medical system. It is for these reasons and more that PVA seeks to secure through the Veterans Administration the very best, the most compassionate, and most comprehensive medical care services this grateful nation can provide.

In keeping with this goal PVA is pleased to endorse the bill introduced by Chairman, G.V. "Sonny" Montgomery to establish a three year pilot program where five VA medical centers would be given increased latitude to test certain management initiatives thereby improving the center's operating efficiency and economies. Hopefully, the savings realized by such management initiatives can be translated into improved medical care service for the veterans being treated or to allow additional veterans a more timely access

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to the system. With more than 35,000 veterans currently being turned away from VA medical centers each month, coupled with the continued need for fiscal constraint, the VA needs to be given the opportunity to try what is being proposed.

PVA would hope the VA selects, and this Subcommittee ensures, that the five medical centers chosen for this pilot program be truly representative of the 172 VA medical units currently serving the veteran population. We would also hope that the efficiencies sought through these studies will not be made at the expense of treating fewer veterans or at the sake of reduced quality of care provided. We trust this will not be the case but since this language is not specifically stated in the bill we think it imperative that such a statement be included just to preclude such from happening.

In this era of fiscal constraint and concern for deficit spending, we simply desire assurances from the VA and the Administration that all that is done in the name of efficiency and economy will not be at the long-term determinant of the veteran patient. Even though we have the utmost respect and confidence in the dedication of the VA hospital Administrators we know too of the zealous glee and influence that the Office of Management and Budget can exercise over the VA when it comes to matters of management efficiencies and monetary savings.

Another aspect of the proposal which is of concern to us stems from the fact that no mention is made of what happens to the savings that hopefully will be realized by the pilot program. We trust that these monies will not simply be channeled into the U.S. Treasury for to do so would provide little incentive

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to the individual hospital Administrators to really optimize the potentials inherent in this pilot program. Rather, PVA would encourage this Subcommittee to add necessary language to the bill to ensure, given proper accounting, that any and all monetary savings realized under this program be set aside in a trust account for use by the individual VA medical center which realized such savings in order that they may further improve or augment the level or quality of care which they in fact provide their veteran patient clientele.

Now, in reference to the "Veterans' Health-Care Amendments of 1986," PVA would like to commend you, Mr. Chairman, for the inclusion of respite care in this bill. We have been a long and ardent advocate of the need for the VA to provide this most necessary and important service to those veterans, who like PVA's members, suffer from chronic medical conditions that need constant attention.

Most individuals with chronic conditions can and do live outside the permanent confines of a hospital or nursing home setting. They do so in large part by personal choice except for the case of many non-service-connected disabled veterans. For most NSCs care outside the VA health-care system is a reality not of choice, but of law, and for those with chronic conditions it is often times a life of dependence upon one's family or primary caregiver to ensure that their unique health-care needs are met. Regardless of circumstance, the need for "respite care" is an ongoing and ever present necessity, not only for the individual with the chronic condition, but equally so for the person or persons who provide the care. The simple provision of an opportunity for "respite care" can often times

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mean the difference of a veteran living a life within an institutional setting or in the community at large. It can also mean the difference between a stable, supportive family setting in the home or the more expensive provision of care in the institutional setting. It is for these reasons PVA strongly applauds today's efforts to include "respite care" as one of the services which the VA can provide for deserving veterans.

In reviewing the definition proposed for "respite care" PVA would encourage this Subcommittee to consider adding hospital-based home care as another viable means of providing the type of assistance intended under this section. We would therefore suggest the following language change: "The term 'respite care' means intermittent or temporary hospital, hospital-based home care, or nursing home care provided to a veteran who has been diagnosed as suffering from a chronic illness or medical condition and who without provision of such care could face the prospect of having to be provided similar services only in an institutional, long-term basis, as determined by the Administrator." This change would enable the VA to provide "respite care" in the veteran's home environment therefore precluding unnecessary travel which for many individuals with chronic disabilities is a difficult and expensive undertaking.

Another concern we have with the proposal for "respite care" has to do with eligibility. We trust that the newly implemented means test will clearly define which veterans will be eligible for respite care services, although we do foresee some difficulty in assessing the cost of providing such service to a veteran. This could, in turn make it rather difficult to determine program eligibility based upon a veteran's "inability to defray the expense of

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respite care." Hopefully though, this concern can be adequately addressed in fine-tuning this legislative proposal.

PVA encourages this Subcommittee to incorporate into the "respite care" proposal some language that will insure the prompt and timely provision of respite care to a veteran when needed. The reason for making this request stems from our xperiences in dealing with chronic medical conditions. It must be remembered that if "respite care" services are going to be provided, it is not the chronically disabled veteran who is in need of emergency medical treatment, it is a situation where the veteran's primary care-giver is unable to provide the necessary care. Therefore, we desire assurance that the veteran who seeks "respite care" will be given the same timely provision of service as that provided any other veteran who seeks necessary medical assistance from a VA health-care facility.

PVA firmly believes that the respite care program, if implemented, will, in the long run, be a very cost-effective, humane, and greatly appreciated form of veterans' health care, especially for those untold thousands of caregivers who are presently providing needed care to chronically disabled veterans and who need and deserve the type of support that a respite care program can provide.

I would like to focus upon Section 8 of the proposed health-care amendments which seeks to make major changes in the VA's State Home Construction Grant Program. In light of the Administration's failure to accept full responsibility for the increasing demands which the aging veteran population

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will be placing upon the VA health-care system, it is most timely and appropriate that this legislation be given serious consideration.

After reviewing the language contained within Section 8, PVA is in full accord with the changes being proposed. In fact, we think the proposals being made should go far toward bringing the State Home Construction Grant Program into a more systematic and evaluative process based more upon the actual needs of a given state rather than by the somewhat restrictive method presently being used. We support the elimination of the one-third provision which restricts a given state from receiving more than one third of the total appropriation granted in any one year. We have long viewed this provision as counterproductive to the program and a penalty to the states that have a serious commitment toward meeting the needs of their veteran population.

We also like the idea of the VA Administrator submitting an annual list of the proposed construction grant projects, prioritized based upon relative need. We think it most appropriate that such a list be submitted to Congress at the same time the President's budget is presented, therefore allowing for this grant program to be viewed in its proper perspective along with the total operating budget of the VA. The prioritized listing of construction projects should also go far in giving actual legitimacy to a given project's need and taking it out of the arena which it has often time fallen into -- that of selection determined by desire, not necessarily greatest need.

We would suggest one minor technical change to the language to be used by the Administrator in determining the relative need for a given project. In item (2) it says "the Administrator shall consider ... (C) the number of other

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facilities in the geographic area of the proposed facility that may be available to provide nursing home or domiciliary care to such veterans;" We would prefer to have part (C) read "the number of other facilities in the geographic area of the proposed facility that may be not only suitable and available but willing to provide nursing home or domiciliary care to such veterans;". By the insertion of this qualifying terminology the VA Administrator should be in much better position to determine the relative need of a given project based less upon the misleading figure of a gross number of facilities available in a given geographic area and more upon the number of facilities which would actually be willing to provide care to the area's veteran population. PVA is concerned that if this qualifying terminology is not included in part (C) that an unrealistic assessment of actual need could be made even when statistics show an adequate number of nursing homes or domiciliaries exist.

It is one thing to have such facilities in existence but it is much more important to know that these facilities are in fact willing and able to provide the care that the veteran population is in need of at the time. We know all too well that many nursing homes are either of improper design or prefer to cater to a more healthy and independent population group as well as giving consideration to patient resources, and that even though these are available they should not be considered as a viable resource facility for the long-term veterans.

I would like to close by stating PVA does support the extension of the VA authority to maintain a facility in the Philippines. We think it important to maintain the stability of that entity in light of the changes that are occurring for this important ally of the United States. Mr. Chairman, that concludes my statement regarding the issues being discussed today. Thank you, I will be happy to answer any questions that I can.